Model Tobacco Use Treatment Benefit Language

The following model benefit language represents a comprehensive tobacco use treatment benefit. While individual elements of this model benefit (e.g., counseling only, medications only) will increase a tobacco users chances of successfully quitting if used in isolation, we recommend a comprehensive benefit that uses all the evidence-based tools at our disposal in order to maximize the impact of this health care intervention and greatly increases the chances for every individual to successfully end their tobacco use dependence.

Findings and Rationale for Benefit

- Tobacco use dependence is widely recognized as a chronic disease that manifests itself in the fact that most tobacco users make multiple quit attempts before successfully quitting.

- Tobacco use dependence causes or complicates most of the Nation's most prevalent and costly chronic diseases (e.g., cancer, heart and lung disease, stroke, diabetes, asthma) and treatment for tobacco use dependence has been established as an integral part of evidence-based care for each of these diseases.

- Tobacco use is responsible for the annual deaths of 440,000 individuals in the United States and for more than $167 billion annually in healthcare costs and lost productivity.

- Half of all tobacco users in the United States never quit and half of continuing tobacco users will die from a tobacco-related illness.

- According to the U.S. Centers for Disease Control and Prevention, men who smoke are absent from work 4 days more per year than men who do not smoke, and women who smoke are absent from work 2 days more each year than nonsmoking women.

- Tobacco use is increasingly correlated with education level and income such that the highest rates of tobacco use are found in individuals with low socio-economic status, low education, and among certain racial/ethnic groups (e.g., Alaska Natives/Native Americans).

- Approximately 7 out of every 10 tobacco users say they want to quit, and nearly half of all tobacco users make a quit attempt each year.

- Less than 1 out of every 3 tobacco users trying to quit makes use of an evidence-based treatment, including FDA-approved medications and proven counseling and behavioral therapies.

- In any given quit attempt, less than five percent of tobacco users are likely to successfully quit without use of an evidence-based treatment (e.g., quitting "cold turkey").

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- Brief interventions of just a few minutes, offered by physicians and non-physicians, significantly improve quit rates. There is a dose-response relationship between treatment intensity and quitting success – more treatment equals higher quit rates.

- The provision of tobacco use treatment advice and assistance (counseling, pharmacotherapy) for adults has been endorsed as one of the 20 priority areas for transforming health care by the Institute of Medicine and as a core healthcare quality (Health Plan Employer Data and Information Set/HEDIS) measure by the National Committee for Quality Assurance (NCQA).

- The U.S. Surgeon General, the U.S. Centers for Disease Control and Prevention, the Institute of Medicine, and the National Commission on Prevention Priorities have all concluded that evidence-based tobacco use treatment services are effective and more than double or even triple a tobacco user's chances of quitting over an unaided quit attempt.

- The U.S. Public Health Service, the U.S. Centers for Disease Control and Prevention, and the Institute of Medicine have concluded that tobacco use screening and intervention is more cost-effective than other common and covered disease prevention interventions, such as screening and treatment for hypertension and high blood cholesterol.

- New findings by the National Commission on Prevention Priorities show evidence-based tobacco use treatments to be the single most effective and cost-effective preventive service for adults in the general population, saving more money in the long run (5+ years) than it costs to deliver and more than all other adult clinical preventive services combined.

Benefit Design

A model tobacco use treatment benefit should include:

1. Screening for tobacco use –

Every patient at every clinic visit should be asked if they use tobacco and should have their tobacco use status documented (in outpatient and inpatient health care visits, including home care and case management) and should be advised and assisted to quit. Documentation of tobacco use should be recorded as part of a patient's vital signs in the patient's electronic or paper medical record.

2. Evidence-based counseling for tobacco use treatment –

(a) The term 'evidence-based counseling for tobacco use treatment', described and recommended by "Treating Tobacco Use and Dependence: A Clinical Practice Guideline", published by the U.S. Public Health Service in June 2000, includes diagnostic and counseling services that combine problem solving and quitting skill training, direct social support, and training in garnering external social support for quitting. Effective counseling can be provided in individual, group and phone counseling formats. Such counseling can be delivered by a variety of clinicians, including:

- by or under the supervision of a physician; or
- by any other heath care or counseling professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished.

(b) The term 'evidence-based counseling for tobacco use treatment' is limited to--

- services recommended in "Treating Tobacco Use and Dependence: A Clinical Practice Guideline", published by the U.S. Public Health Service in June 2000, or any subsequent modification/update of such Guideline; and
- such other services that the State Secretary/Commissioner of Health recognizes to be effective.

3. Evidence-based pharmacotherapy –

As described and recommended by "Treating Tobacco Use and Dependence: A Clinical Practice Guideline", published by the U.S. Public Health Service in June 2000, the term 'evidence-based pharmacotherapy' includes all pharmacologic agents, prescription and over-the-counter products, approved by the U.S. Food and Drug Administration for the treatment of tobacco use dependence (including nicotine transdermal patches, nicotine polacrilex gum, nicotine lozenges, nicotine inhaler, nicotine nasal spray, bupropion SR, and varenicline, or any subsequent products approved by the FDA for the same purpose) along with required diagnostic and medication counseling services. These products shall be covered individually and in combinations recommended by "Treating Tobacco Use and Dependence: A Clinical Practice Guideline" and published by the U.S. Public Health Service in June 2000 (or any subsequent updates of such Guideline).

4. Duration of treatment –

Due to the chronic, relapsing nature of tobacco use dependence, a disease that often requires multiple quit attempts in order to achieve long-term abstinence from tobacco, counseling and pharmacotherapy shall be available for multiple episodes of treatment per benefit year with no lifetime limit.

5. Targeting benefits –

If specific population groups have been identified (e.g., pregnant smokers) to receive medically appropriate tobacco use treatment services, the benefit design (counseling and pharmacotherapy) must be tailored, consistent with the scientific evidence-base for tobacco use treatment, to the unique needs of that population.

6. Unlinked vs. linked medication benefits –

All providers are strongly encouraged to combine counseling with pharmacotherapy when clinically appropriate. The receipt of counseling or pharmacotherapy shall not be a precondition for the use of one form of treatment (e.g., counseling) in order to receive the other (e.g., pharmacotherapy).

7. Cost-sharing and deductibles –

Patients' out-of-pocket treatment costs (e.g., deductibles, cost-sharing) for all forms of evidence-based counseling and pharmacotherapy for treatment of tobacco use shall be eliminated or minimized to remove financial barriers to treatment.

8. Adequacy of reimbursement –

Provider, clinic, heath plan and hospital reimbursement for services rendered under this benefit shall be sufficient to cover the reasonable and necessary costs for the delivery of tobacco use treatment services incurred by covered providers and health systems.

9. Promotion, education and awareness –

Sustained efforts, including employer and community-based outreach activities, to educate and promote awareness of tobacco use treatment services, among consumers and health care systems and providers, shall be conducted in an effort to increase utilization and quit rates of all evidence-based tobacco use treatment services.

10. Data collection and evaluation –

Data shall be collected at a minimum for the purposes of monitoring and reporting on the delivery of recommended tobacco use screening and treatments (consistent with the measures required by the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations) and optimally for the purpose of evaluating the clinical and economic impacts of the tobacco use treatment benefit (use of data from billing code ICD-9 305.1 is recommended for this purpose).

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