

Colorado Tobacco Cessation & Sustainability Partnership

A Case Study



A Collaborative Approach to Meeting the U.S. Preventive Services Task Force Recommendations on Tobacco Cessation Screening and Intervention



Colorado Department
of Public Health
and Environment



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A Case Study of Colorado's Tobacco Cessation and Sustainability Partnership

Foreword

Partnership for Prevention's ActionToQuit initiative is pleased to have commissioned this case study to tell the story of Colorado's journey toward comprehensive tobacco cessation coverage. It describes the work of the Colorado Tobacco Cessation and Sustainability Partnership to assess the state's political environment, gather and use data, and develop strategies to create change. The lessons that Colorado's tobacco control leaders have learned in working with public and private insurers to implement the U.S. Preventive Services Task Force's A & B recommendations will be of great value to other states as federal health reform is implemented. Advocates in many states have begun to work with their health plans to address coverage for tobacco cessation and other preventive services. It is Partnership for Prevention's hope that Colorado's pioneering efforts will be shared widely to the benefit of leaders and advocates who undertake similar work.

Partnership for Prevention seeks to create a "prevention culture" in America, where the prevention of disease and the promotion of health, based on the best scientific evidence, are the first priorities for policy makers, decision-makers, and practitioners. ActionToQuit is a tobacco control policy initiative that urges all sectors – employers, insurers, health care systems, quitlines and policymakers – to work together to ensure that all tobacco users have access to comprehensive cessation treatments.

Jud Richland
President and CEO
Partnership for Prevention

The Colorado Department of Public Health and Environment gratefully acknowledges the Tobacco Cessation and Sustainability Partnership (TCSP) for its dedication and commitment to addressing tobacco cessation coverage for Colorado smokers. For more than two years, TCSP members met monthly to educate themselves on the many challenges and issues of benefit coverage, to develop strategy and to collaboratively design tobacco cessation coverage for Colorado. Through the efforts of our diverse and committed TCSP members, the majority of Colorado smokers have access to free or low-cost evidence-based cessation services and the sustainability of the state's QuitLine has been enhanced.

We hope by sharing Colorado's journey, other states will form the public and private partnerships needed to ensure evidence-based tobacco cessation services are a standard of care available to all smokers.

Deb Osborne
Health Systems Director
Colorado Department of Public Health and Environment

Overview

In the spring of 2010, the federal Patient Protection and Affordable Care Act (PPACA) was enacted. Similar to legislation passed in Colorado the previous year, PPACA requires most health plans to provide coverage for clinical preventive services designated as “A” or “B” recommendations by the U.S. Preventive Services Task Force (USPSTF)¹. One “A” recommendation is for clinicians to ask all patients about tobacco use and to provide tobacco cessation interventions for tobacco users. As Colorado learned implementing state legislation, this evidence-based recommendation for health care providers poses challenges for health plan administrators, state regulators, health care providers and public health professionals. Identified challenges include:

- How can states support health plans in providing evidence-based tobacco screening and cessation interventions cost-effectively?
- Where is the balance between public and private funding for treating tobacco dependence?
- How are the USPSTF recommendations translated into defined benefits and implemented among health plans?

More than a year before PPACA was enacted, a group of Colorado’s key stakeholders – health plans, state agencies, clinicians and public health advocates – were engaged in a collaborative process to address many of these challenges. This “Tobacco Cessation and Sustainability Partnership (TCSP)” quickly became instrumental in expanding cessation coverage in Colorado and building a framework to support the sustainability of the state’s QuitLine. The TCSP enlisted Colorado’s major health plans in covering QuitLine costs for their members through the development of a Partnership Plan, worked with Colorado’s Medicaid program to increase its pharmacotherapy benefit from once in a lifetime to twice yearly, and convinced the State of Colorado to provide comprehensive tobacco cessation benefits to state employees.

Colorado’s collaborative efforts to address tobacco cessation coverage challenges were instrumental in providing tobacco users with effective cessation services in the face of declining state tobacco prevention and control program funding. This case study describes the role and activities of the TCSP, explains components of the Partnership Plan and summarizes key lessons learned in implementing the USPSTF “A” recommendation for treating tobacco dependence. These lessons can provide a road map for other states and territories working to implement the PPACA’s requirements for treating tobacco dependence.

¹ The federal Patient Protection and Affordable Care Act (PPACA) requires insurers and plan sponsors (e.g. self-insured employers) to modify their coverage to comply with significant new insurance market reforms. Many of these are effective the first plan year on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans). However, PPACA “grandfathers” certain plans that were in existence on the date of enactment from some of the insurance market reform requirements.

1. Background

In 2004, Colorado voters approved an increase in the state's tobacco excise tax that led to the growth in funding and utilization of the Colorado QuitLine. It soon became one of the most used quit lines in the country, with a quit rate of 34 percent at six to seven months post program enrollment. At the program's peak funding level, the QuitLine served an average of 4,000 smokers per month. During this time, Colorado's adult prevalence rates dropped from 20 percent in 2003 to 17.6 percent in 2008.

Just as the QuitLine was hitting its stride, however, Colorado experienced an economic downturn, tobacco resources were diverted to other state health programs and tobacco tax revenues dropped with the decline in tobacco rates. Despite significant funding reductions, the QuitLine continued to provide all callers, regardless of insurance status, five proactive coaching calls, four weeks of nicotine replacement therapy and free access to the state's online cessation service. More than 30 percent of callers reported having private health insurance, but none of the health plans covered the cost of QuitLine services.

The Tobacco Review Committee, a 16-member statutorily appointed state board that oversees the allocation of tobacco tax revenues and ensures compliance with legislative requirements, cautioned the Colorado Department of Public Health and Environment (CDPHE) that tobacco program funding, even at the QuitLine's now reduced level of 2,000 callers per month, would be difficult to maintain with the decline in tobacco tax revenues and further state budgetary uncertainty. The Review Board directed tobacco program staff to explore opportunities for other QuitLine funding sources.

CDPHE commissioned an assessment of the tobacco cessation landscape in Colorado to explore funding options. Through a review of state-specific health plan data, an assessment of major health plans' cessation benefits and an analysis of the political support for tobacco cessation, recommendations were made on how to preserve access to comprehensive evidence-based tobacco dependence treatment for Colorado tobacco users.

The key findings and recommendations included:

- Health plans' coverage of and support for tobacco cessation can be improved.
- Health plan purchasers, providers and state government are primary partners in efforts to promote health plan coverage for and support of tobacco cessation.
- Mandates (benefits and reimbursement) are the least desirable starting point for improving health plan coverage because they alienate too many natural partners or allies in the effort to promote tobacco cessation and only impact about a third of Colorado lives.

- Although mandates may not be a desirable starting point, it is a fallback position that should not be ignored.

Major Recommendations:

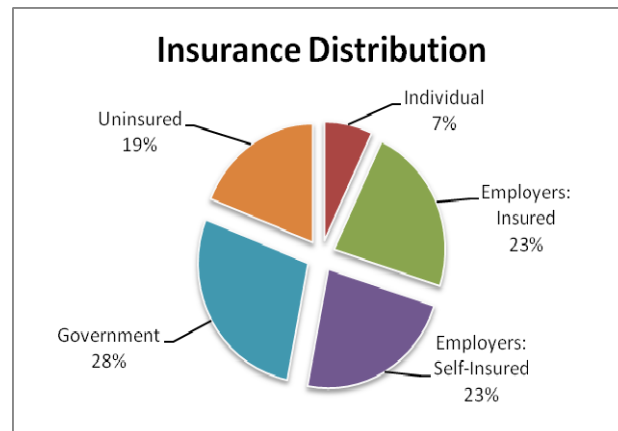
- Identify and utilize natural partners who can provide insight, expertise and leverage to bring health plans to the table.
- Work directly with health plans to promote their knowledge and use of existing state services (e.g. provider education, fax referrals, QuitLine and educational material).
- Lead by example by providing better coverage for tobacco cessation for state employees and use the state's leverage as a major purchaser to bring health plans to the table to discuss coverage and reimbursement.
- Maintain the possibility of mandated coverage but consider enhanced reporting requirements to better monitor and track voluntary coverage and payment trends.
- Support new and ongoing efforts to educate purchasers about the value of providing tobacco cessation benefits. Modify or enhance QuitLine operations and services to attract new constituents, namely health plans and employers.

Acting on one of the first recommendations, CDPHE convened a group of key stakeholders to establish the Tobacco Cessation and Sustainability Partnership (TCSP) and charged the group with reviewing, prioritizing and implementing the remaining recommendations. TCSP membership was by invitation only to ensure members had decision-making authority for the organizations they represented. CDPHE also recognized the need to reach beyond traditional tobacco prevention and cessation partners to engage stakeholders representing the public and private sector. As a result, TCSP membership included representation from the state's health plan association, business associations, a medical society, volunteer associations, advocacy groups, academia, quit line services, health disparities organizations, local and state public health and the state's Medicaid program.

After reviewing the assessment key findings and major recommendations, one of the first decisions TCSP had to make was whether to try to achieve health plan tobacco cessation coverage through voluntary policy changes or legislative mandate. During the previous legislative session, the Colorado Association of Health Plans (CAHP) had been instrumental in defeating legislation that would have required member health plans to cover the costs of colorectal cancer screening. While the CAHP executive director recognized the need for health plans to become more proactive in addressing wellness issues, and believed tobacco represented a possible win-win, legislative mandates for tobacco cessation coverage

remained problematic. Many CAHP members believed they already provided tobacco cessation coverage and that neither employer nor individual purchasers were asking for additional benefits.

Understanding the political environment, TCSP recognized that a legislative mandate could risk antagonizing key parties – employers, health plans and physician groups – that could become natural allies in efforts to improve tobacco cessation options for all tobacco users. TCSP members also were concerned that a legislative mandate might increase insurance costs to employers and individuals while reaching a limited segment of tobacco users. Approximately half of Colorado citizens are either uninsured or covered by some form of public insurance and nearly 25 percent are covered by employer self-insured plans. As mandates apply to only 30 percent of the insured population, they were deemed a poor starting point.



As the 2009 legislative session unfolded, two significant events changed the political landscape. First, House Bill 09-1204 was introduced with support from one of CAHP’s member health plans. The bill mandated that health plans provide certain prevention benefits outlined in the USPSTF “A” and “B” recommendations and limited the ability of health plans to require cost-sharing for those benefits. CAHP and its member health plans reversed their long-standing opposition to mandates and endorsed the bill. The CAHP executive director stated that a key turning point for the plans support of tobacco coverage was evidence-based research and data demonstrating that cessation programs are cost-effective and provide a return on investment to third party payers. HB 1204 was enacted by the legislature and signed into law by the Governor in June 2009, with an effective date of Jan. 1, 2010.

Second, the General Assembly invoked the “fiscal emergency” clause in the 2004 constitutional amendment that increased the tobacco excise taxes. By declaring a “fiscal emergency,” the General Assembly was able to reappropriate dedicated tobacco tax revenues, including tobacco prevention and control program appropriations, to the general fund as part of the effort to manage the state’s budget deficit. This resulted in a 50 percent cut in QuitLine funding. After reviewing the options, CDPHE continued providing QuitLine services for all Coloradans, but targeted outreach and promotion efforts toward three priority populations: uninsured persons, Medicaid recipients and pregnant women.

Tobacco users with health insurance faced the possibility of being turned away from the QuitLine beginning July 1, 2009, depending on funding availability.

2. TCSP Action Steps

State coverage mandates paired with state budget reductions created an opportunity for the TCSP to focus its efforts on assisting health plans meet new state requirements while preserving funding for QuitLine services. Its decision not to take a position on the legislative mandate during the 2009 legislative session and to work instead on promoting voluntary policies positioned the TCSP as a forum where alternative solutions could be considered and discussed in an open, non-adversarial atmosphere. It also enabled TCSP members to collaborate on the group's priorities.

TCSP established five priorities to develop its work plan:

1. Translate the language of the USPSTF tobacco recommendation into an evidence-based cessation coverage standard to recommend to all health plans
2. Advocate evidence-based cessation coverage for Medicaid
3. Support adding evidence-based cessation coverage to all state employee benefit plans
4. Educate health plans about cessation benefits and identify mechanisms to promote coverage
5. Develop and utilize relationships with large employers to leverage efforts for better health plan cessation coverage

During its first six months, TCSP made significant progress on development of an evidence-based cessation coverage standard, cessation coverage for state employees and expansion of the Medicaid pharmacotherapy benefit. There was considerable debate among TCSP members with regard to whether the cessation coverage standard should be a "gold-standard" versus a "baseline" benefit. The gold-standard benefit represented the most effective evidence-based benefit, whereas the baseline benefit was designed to assist health plans meet the state mandate and quickly implement a benefit. After thorough review of research and much discussion, TCSP adopted an evidence-based cessation baseline benefit (see Appendix). The baseline benefits were described in language familiar to health plans and covered screening, counseling, pharmacotherapy, lifetime limits and patient out-of-pocket expenses.

Colorado is the largest employer in the state, yet the state employee health insurance plan offered minimal tobacco cessation benefits. The State reviews its current employee health insurance benefit plan every five years and was beginning the process during this time. In order to educate state decision makers, the TCSP prepared a detailed briefing book comparing the state's tobacco cessation benefits to those of other

states and the Centers for Disease Control and Prevention (CDC) guidelines. The briefing book included detailed evidence on the cost-effectiveness of tobacco cessation services for employers and calculated the return-on-investment using state data. In early June, CDPHE and TCSP staff met with state personnel administrators and the committee charged with developing the state employee health benefits request for proposal (RFP). When the state released its RFP, it included tobacco cessation as the only named wellness benefit.

State Medicaid benefits for smoking cessation were similarly limited. In the summer of 2008, a group of public health advocates organized by the National Hispanic Nurses Association (NHNA) and the American Heart Association Colorado Chapter wrote a letter to the governor of Colorado criticizing the state's limited coverage of tobacco cessation options under the Medicaid program, especially the coverage of only one quit attempt in the lifetime of the beneficiary. One of Denver's major newspapers covered the issue and reported the concerns of advocates and Medicaid recipients. CDPHE was already reviewing the issue. During fall 2008, advocates participated in a series of meetings with representatives of the Governor's Office, CDPHE and the state Department of Health Care Policy and Finance (HCPF), which administers the Medicaid program. While public health advocates pressed for action, TCSP provided data demonstrating the cost-effectiveness of cessation services for the Medicaid program. HCPF announced it would begin providing nicotine replacement therapy coverage Sept. 1, 2009, for as many as twice-yearly quit attempts by Medicaid recipients previously limited to a once in a lifetime benefit.

TCSP had defined a minimum set of recommended cessation benefits and catalyzed demand for tobacco cessation coverage from the largest public purchasers of health care in the state: the State employees' health benefit program and Medicaid. TCSP efforts influenced public sector purchasers and enhanced TCSP's credibility with CAHP members. TCSP next recommended a summit meeting of key health plan decision makers to lay a foundation for another major TCSP priority – improving access to comprehensive evidence-based tobacco cessation services, including the QuitLine, for insured employees of private companies.

3. Engaging Colorado's Health Plan Providers

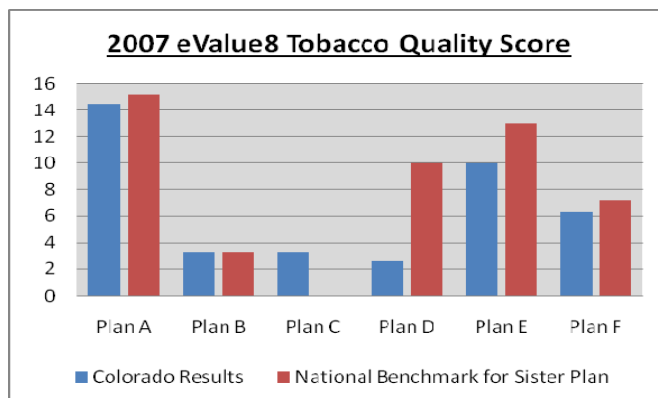
Following passage of HB-1204, CDPHE's chief medical officer and CAHP's executive director invited the leadership of Colorado's health plans and members of the TCSP to discuss options for a cost-effective, public-private partnership to support tobacco cessation coverage and assist health plans' compliance with the new law. Representatives from all of Colorado's major health plans and TCSP members attended. Three key messages were delivered:

- The evidence base demonstrates that treating tobacco use and dependence is cost-effective for employers and health plans. The National Commission on Prevention Priorities, convened by Partnership for Prevention, ranks smoking cessation as its top clinical preventive service based on the health benefit and cost effectiveness.
- There is a strong body of science that identifies cessation interventions and pharmacotherapies are effective.
- Tobacco cessation is recognized as the most cost-effective employee health benefit by the CDC and the National Business Group on Health.

Evidence used to support these messages includes:

- Data on quit rates with and without assistance (QuitLine support, other counseling and pharmaceutical aids)
- Per member per month costs and return on investment (ROI) using an ROI calculator developed by America’s Health Insurance Plans (AHIP)
- The cost-effectiveness of tobacco cessation coverage compared with mammograms, colorectal cancer screening, alcohol screening and pap smears, already acknowledged as core elements of good plan design

TCSP presented data from health plans responding to the National Business Coalition on Health’s eValue8 Request for Information on current coverage of tobacco cessation, comparing their performance with each Colorado health plan’s benchmark “sister plan” in other states. Analyzing these data, TCSP established that tobacco cessation services were reaching a much smaller percentage (less than 1 percent, in most cases) of health plans’ members than the percentage of tobacco users ready to quit in the general population. Individual health plan data were not identified in order to demonstrate that all health plans had substantial room for improvement in coverage and performance.



4. Forging the Partnership Plan

The information gathered from eValue8 revealed that Colorado health plans’ cessation coverage for both counseling and pharmacotherapy fell short of USPSTF recommendations and Colorado’s new law.

Following the joint meeting with the health plans, TCSP and CDPHE began formulating a proposal that would enable the health plans to meet their HB-1204 requirements and preserve access to the QuitLine for all Coloradans. Understanding the time required for health plans to adopt a new program and the complexity of triaging callers according to insurance status, CDPHE announced that QuitLine services would remain available to all tobacco users until at least Oct.1, 2009. However, after that date, QuitLine services would be prioritized to serve the uninsured, Medicaid recipients and pregnant women, depending on the budget. Throughout the summer and early fall, TCSP and CDPHE remained in contact with the health plans and sought to engage them in efforts to expand the public-private partnership to include discussion of health plans' financial support for the QuitLine as a component of their HB-1204 compliance. The messages were clear:

- Without health plans' support of their members' QuitLine use, the QuitLine would no longer be able to provide cessation services to those members.
- Supporting QuitLine health plan member use can be considered a major component of health plans' mandated tobacco cessation coverage.

QuitLine data showed that 37 percent of users were covered by private insurers. At the low end, one health plan that operated its own quit line accounted for 3 percent of QuitLine users; at the other end, one health plan's members represented 15 percent of all QuitLine users. All Colorado health plans had some degree of QuitLine utilization, but their willingness to be part of a global solution to QuitLine sustainability varied from health plan to health plan. However, all health plans would potentially be affected, to varying degrees, from loss of access for members seeking QuitLine services.

In September 2009, the TCSP held another meeting with health plan executives and presented "The Partnership Plan," a proposal through which health plans would cover their share of QuitLine costs. The Partnership Plan envisioned a system in which National Jewish Health, CDPHE's QuitLine contractor, would continue to provide QuitLine services to health plan members with the same benefits as all other callers:

- Nicotine replacement therapy (NRT) at cost for four weeks, shipped to the members' homes (with the possibility of four additional weeks depending on the level of tobacco use)
- As many as five outbound counseling calls from QuitLine to the member
- Unlimited inbound calls from the member to QuitLine
- Access to limited online cessation services

Access to other pharmacotherapy, such as varenicline or sustained-released bupropion, was not included.

QuitLine callers would receive the same treatment whatever their insurance status. National Jewish Health would bill the state for Medicaid, uninsured and self-insured callers, and bill the participating health plans for their insured member callers.

The health plans expressed some hesitation and concerns. For example, some health plans worried that they might lose revenues from NRT co-pays if their members accessed the NRT through the QuitLine instead of directly from health plan providers, as National Jewish had no mechanism to collect co-payments from callers. A TCSP analysis, however, demonstrated that savings from getting NRT at cost through the Partnership Plan would outweigh lost co-payments.

As negotiations moved forward, CDPHE extended the deadline to impose restrictions on access to QuitLine services to Jan. 1, 2010. As the deadline approached, the TCSP urged health plans to participate in the Partnership Plan and held many one-on-one meetings with health plans to discuss the details. As the guest speaker at a December health plan meeting, the Governor of Colorado recognized the importance of the public-private partnership developed through the Partnership Plan. Heightened media interest in informing the public about which health plans were and were not participating also created momentum for health plans to join the Partnership Plan.

By year's end, Colorado's nine major health plans opted to participate in the Partnership Plan. Participation in the Partnership Plan offset the state's QuitLine costs by 12 to 14 percent. While cuts in outreach and promotional budgets have reduced the overall volume of calls to the QuitLine, the distribution among public and private insured and uninsured remained the same as before the Partnership Plan was implemented.

5. Implementation Challenges

To better understand how Colorado health plans had interpreted the state and PPACA prevention requirements, including those for tobacco cessation benefits, CDPHE, in collaboration with TCSP, surveyed representatives from health plans participating in the Partnership Plan. Seven health plans responded, and the results indicated that challenges remain in ensuring consistency in interpretation and implementation of the statutory requirements. Health plans reported the following restrictions in the coverage for tobacco screening and pharmacotherapy:

- Health plans need to come to a common understanding of federal and state requirements for coverage of all recommended cessation pharmacotherapies. Survey responses indicate pharmacotherapies beyond NRT are not universally covered, with some health plans placing restrictions on the availability of varenicline and sustained-released bupropion. Several health plans explicitly indicated

that they do not believe pharmacotherapy is a required benefit. Only one Colorado health plan currently offers all FDA-approved medications with no restrictions. The confusion arises because the USPSTF “A” recommendation for tobacco coverage does not specifically mention coverage of pharmacotherapies. However, the more detailed U.S. Public Health Services 2008 Clinical Practice Guidelines A and B recommendations are referenced as the foundation for the USPSTF recommendation. Under the Clinical Practice Guideline, all FDA-approved tobacco cessation pharmacotherapies are an “A” recommendation and an integral component of the recommended tobacco intervention.

- Some health plans have limitations on use of reimbursement codes for tobacco cessation, e.g. a requirement that services be provided only by primary care providers and limits on the use of reimbursement codes to service provided for group, but not individual, policyholders.
- Only one of the health plans communicated with their members and health care providers about changes in the availability of cessation coverage required by HB-1204 and provided under the Partnership Plan. This is surprising because of the favorable cost-effectiveness of broader use of cessation services. There has been little increase in use of the services and without better marketing strategies this trend is likely to continue.

This lack of uniform interpretation of the USPSTF recommendations and limited communication to members or providers in Colorado are likely to be reflected on a much larger scale with federal health care reform. To ensure optimal consumer and health care provider utilization of preventive benefits, it is critical that the A and B recommendations are clearly defined in health plan benefit language, processes are put in place for consistent implementation, and these new benefits are communicated to both consumer and provider. The experience of Colorado shows that public health can play a key role in successfully implementing the PPACA prevention services provisions.

6. Keys to Success

- The “Perfect Storm” – The development of the state’s employee health insurance RFP; a letter from public health advocates to the Governor calling for expansion of Medicaid cessation benefits at the same time CDPHE was raising the issue internally; the declining budget jeopardizing the capacity of the QuitLine to continue to serve all callers; the passage of state legislation requiring coverage of tobacco cessation; and the health plans’ recognition of the return-on-investment for tobacco coverage set the stage for collaboration among health plans and public health.
- Collaborating with partners – The TCSP was formed to bring together key players to address cessation issues. Prior to the passage of HB-1204, TCSP had already established a non-adversarial

forum focused on mutual education and collaborative problem solving outside of the legislative process. Stakeholders used the TCSP as a resource to forge solutions. The TCSP's culture of collaboration was further reinforced by the use of an external facilitator for meetings.

- Establishing and building trust – By recognizing that mandates could potentially make adversaries rather than allies, the TCSP built a culture of trust and credibility with health plans. CDPHE participated in the TCSP as a member of the group, not as the funder and formal leader. Both internally and externally, TCSP and CDPHE actions promoted the neutrality of the group and enhanced buy-in for TCSP priorities and strategies.
- Recognizing the state's responsibility – The TCSP gained additional leverage with private health plans by focusing its efforts first on the publicly-funded state employee and Medicaid benefit plans that covered the largest employer in the state and the largest percentage of publicly insured Coloradoans.
- Understanding partners to bridge the language divide – A key role for TCSP has been, and continues to be, translating the policy- and outcome-oriented language of legislative mandates such as HB-1204 and PPACA into specific health plan language that is meaningful and workable for health plan operations. To accomplish this requires the participation of a person or persons well versed in the health insurance system. This role was played by the TCSP facilitator, who had a deep understanding of the language and operations of the health insurance industry.
- Educating members – Significant time was allotted in early TCSP meetings for mutual education among members. Educational materials developed throughout the process continued to emphasize the importance of bridging the different cultures of public health policy makers and health insurers. Several participants credited this education and exchange process, particularly with respect to the language and operations of the health plans, as key to reaching workable solutions such as the Partnership Plan.
- Engaging diverse members – While sometimes creating logistical challenges, the broad, inclusive TCSP membership ensured that multiple perspectives were considered by the group during a time of great changes and evolution in health care. One public health advocate noted that the ability to consider a problem from the perspectives of patients, health care providers, employers/purchasers, and insurance carriers in the same forum was immensely helpful in understanding the true nature of the challenges and in evaluating possible solutions.
- Using external leverage points – Notwithstanding the success achieved using a collaborative approach, the role of outside leverage on health plans and other stakeholders to use the TCSP as a resource to forge solutions cannot be underestimated. The passage of HB-1204 and the budget crisis

- created an urgency to address cessation issues. Media coverage – and particularly the desire of the local business journal to report on which health plans were signing onto the Partnership Plan and which were not – provided a strong impetus for all health plans to participate. Each health plan risked appearing unsupportive of prevention and risked purchasers switching to other health plans if they did not participate in the Partnership Plan. Even before the TCSP was formed, the public health advocates' letter to the Governor pointed a spotlight on the state's Medicaid program and supported later efforts to seek workable solutions to the gaps in Medicaid coverage. On several key issues, the combination of outside pressures and a commitment to a collaborative approach within the TCSP were complementary forces.
- Identifying and creating effective leadership – Credible leadership also was important to the process. The joint invitation from CDPHE's medical director and CAHP's executive director was effective in prodding health plan executives to participate in the inaugural meeting that laid a foundation for the Partnership Plan. Public health advocates noted the important role played by the HCPF medical director in supporting changes to Medicaid cessation benefits.
- Providing data – Credible data and peer-reviewed research provided a critical foundation for discussion. Health plan performance metrics such as HEDIS/NCQA data and the information extracted from the eValue8 Request for Information provided key information about existing health plan coverage and activities in Colorado and other states. The ROI Calculator from Americas Health Insurance Plans was also used effectively to communicate the potential for win-win solutions.
- Being flexible – The environment shifted significantly during these years with state and federal health care reform and the recession. TCSP modified its tactics frequently to continue identifying ways to help its stakeholders respond to shifting priorities.

7. The Road Ahead

With the passage of the federal PPACA, Colorado's health plans now are required to extend cessation coverage beyond Colorado's insurance mandate to include employees of self-insured employers. Self-insured companies pose some new challenges. Many self-insured companies are larger and operate in multiple states. Both employees and companies have an interest in ensuring that benefits available to all employees are equivalent across states. While the Partnership Plan offered a customized solution to

Colorado companies, responsive to Colorado-specific needs, it is not available in other states and therefore not ideal for multi-state employers. However, the lessons learned from the TCSP's first successful years will continue to inform the search for solutions to self-insured companies and full implementation of HB 1204 and PPACA.

Lack of clear regulatory oversight and a clear definition of the tobacco benefit will continue to pose problems on a much larger scale with the implementation of federal health care reform.

In Colorado, the TCSP kept the issue front and center where it might otherwise have been lost given the volume of other issues health plans must address with health care reform. TCSP played a significant role in helping forge consensus for enhancing cessation services in publicly-funded health benefit plans, in developing and securing buy-in from private health plans for the Partnership Plan, in offering education and technical assistance to health plans as they implement the requirements of HB 1240 and PPACA, and in promoting and reinforcing the value of financially supporting access to QuitLine services for members of private health plans.

However, more work is required to ensure improved communication about the availability of cessation benefits and to promote more consistent interpretation of state and federal statutory requirements for tobacco cessation services. Plans are in place to reconvene health plan leaders to address inconsistencies in tobacco coverage and explore how best to increase use of the Partnership Plan among self-insured employers.

Additionally, Colorado is embarking on a new initiative to build a more collaborative system to address health promotion and disease prevention. The Colorado Prevention Council, a partnership among health plans, community stakeholders, employers, public health professionals and members of the Colorado Cancer Coalition, is being formed to increase the effectiveness of and public-private collaboration for disease prevention activities. With the changing health care landscape over the next five years, the ability to work together to support disease prevention will become increasingly important.

As the federal government, states and territories continue to move toward a more integrated approach to preventive health, the Colorado TCSP model for engaging health plans to implement USPSTF “A” recommendations for cessation coverage can be applied to implementing other “A” and “B” recommendations for preventive health services.

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TOBACCO CESSATION AND SUSTAINABILITY PARTNERSHIP

Recommended Summary Plan Description Language for Insured Employers Baseline Tobacco Cessation Covered Benefits

Effective January 1, 2010, HB 09-1204 requires that all individual and group health insurance policies offered to residents of Colorado shall provide coverage for preventive health care services that receive an A or B recommendation from the United States Preventive Services Task Force (USPSTF). Coverage shall not be subject to policy deductible or coinsurance. Copayments consistent with the overall benefit plan are permitted. Likewise, under the federal Patient Protection and Affordable Care Act, effective September 23rd, 2010, all non-grandfathered employers offering coverage must offer all USPSTF A and B recommendations. However, the federal requirements do not permit any member cost-sharing for these services. The benefits outlined below are consistent with the Affordable Care Act.

Screening

Coverage: Routine screening for tobacco use is a covered benefit.

Frequency: Screening is conducted on a regular basis.

Counseling

Coverage: Counseling (telephonic or face-to-face through individual or group sessions) is a covered benefit for tobacco dependence treatment.

Restrictions: Counseling is offered but not required as a condition of receiving other cessation benefits.

Frequency: Multiple courses of counseling are offered per calendar year with no requirement regarding number of sessions or duration of sessions.

Evidence: There is a dose-response relationship between the number of counseling sessions and quit rates. More sessions increase quit rates with evidence that counseling up to 300 minutes per course of treatment has the greatest effectiveness.

Pharmacotherapy

Coverage: All FDA-approved nicotine replacement products and tobacco cessation medications (over the counter and prescription) are covered.

Restrictions: Provision of medications is not linked to enrollment in counseling or coaching.

Frequency: At least two courses of treatment per year. *

Evidence: Pharmacotherapy has demonstrated quit rates of up to 44 percent. Combining counseling (telephonic or face-to-face) with pharmacotherapy is even more effective.

Lifetime limits

Coverage: Benefits cover at least two quit attempts a year with no lifetime limit on counseling or pharmacotherapy. *

Restrictions: Coverage is not tied to diagnosis of a tobacco-related medical condition.

Patient out-of-pocket

Covered treatment should include no employee cost-sharing.

Evidence: Research has demonstrated that the cost of treatment keeps people from accessing treatment. Conversely, free and accessible treatment increases participation and overall quit rates.

*USPSTF is silent with respect to frequency and payment so the Tobacco Cessation and Sustainability Partnership deferred to the evidence-based Centers for Disease Control recommendations regarding frequency and payment.



Colorado Department
of Public Health
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Action TO QUIT
Advancing Tobacco Control Policy