

BENEFIT RIDER OVERVIEW

Why Provide Smoking Cessation Benefit Coverage?

Tobacco use is the leading preventable cause of premature death in the United States.¹ More than 20% of the adult population smokes.¹ According to the Centers for Disease Control and Prevention (CDC), the annual economic burden in the United States associated with smoking is substantial—\$167 billion each year between 1997 and 2001.² Much of this is related to medical expenses for smoking-related illnesses and lost productivity.^{3,4}

Cigarette smoking is not a lifestyle issue. Nicotine addiction from cigarette smoking is a chronic relapsing medical condition⁵ that requires a multimodal approach to treatment for many smokers. Smoking cessation therapies are available to help patients quit smoking despite this powerful addiction. Medical literature has shown that when pharmacotherapy for smoking cessation is combined with behavioral modification support, including counseling, long-term quit rates may double.⁶ Furthermore, the effectiveness of counseling increases with the intensity of the services provided.⁷

Availability of interventions through a health plan increases the likelihood that smokers will take advantage of smoking cessation programs.^{8,9} However, many health plans do not offer coverage for these interventions. Despite the increasing public focus on smoking cessation, systematic literature reviews have demonstrated that pharmacotherapy and counseling for smoking cessation are not consistently provided as paid services for health insurance subscribers.¹⁰ A recent publication by Walker and colleagues demonstrated that, although some managed care plans cover pharmacotherapy for smoking cessation, many still offer no coverage; therefore, many smokers do not have access to smoking cessation benefits.¹⁰ According to the CDC, although 66% of Americans under the age of 65 are insured through an employer, only 24% of employers offer coverage for treatment of tobacco use.⁷ Nevertheless, some health care payers are moving toward investing in smoking cessation programs and pharmacologic treatments to assist patients in quitting.⁷

What Is a Benefit Rider?

Standard health benefit policies often do not include coverage for all medical conditions. Payers who want to add benefit coverage not included in the original policy, such as smoking cessation treatment coverage, use a benefit rider. A benefit rider acts as an addendum to the original policy.

Why Offer or Request a Smoking Cessation Benefit Rider?

Smoking cessation benefit riders may be beneficial to both payers and purchasers due to decreased health care use. Smokers are reported to make about 6 more visits to health care providers per year compared with nonsmokers.¹¹

Designing a Smoking Cessation Benefit

Knowledge of the value of smoking cessation therapy options, including quit rates, is essential to the design of a benefit. Some suggestions for preparing to design a smoking cessation benefit are that:

- Managed care organizations/pharmacy benefit managers (MCOs/PBMs) review new therapies as they become available and make decisions about formulary addition
 - A smoking cessation category may need to be added if none exists
- Employers and unions ask MCOs/PBMs to include a smoking cessation rider to cover effective therapies, including prescription medications
- Employers and unions request smoking cessation options in their 2008 RFP

BENEFIT RIDER OVERVIEW

CDC Smoking Cessation Coverage Recommendations

Based on a review of studies by Warner, Cummings, and Coffield, the CDC concludes that smoking cessation therapy is the single most cost-effective health insurance benefit that can be offered.⁷ The design of a benefit rider for smoking cessation should include 2 specific areas of coverage—behavioral modification and pharmacotherapy (coverage may be separate or together). The benefit rider should also address the number of smoking cessation quit attempts that will be permitted per year (CDC recommends that plans cover a minimum of 2).⁷

Areas of Coverage	Reason for Coverage
<p>Behavioral modification (may include telephone, Internet, or in-person individual or group sessions)</p> <ul style="list-style-type: none">• Cover at least 4 counseling sessions of at least 30 minutes/attempt⁷	<ul style="list-style-type: none">• Behavioral modification helps smokers change habits and behaviors associated with smoking¹²• Counseling increases the rate of successful quitting⁶
<p>Pharmacotherapy coverage (prescription benefits for medications requiring a prescription; consideration for reimbursement of over-the-counter products)</p> <ul style="list-style-type: none">• Copays and deductibles should be minimized and/or eliminated⁷	<ul style="list-style-type: none">• Lack of coverage can be a barrier to treatment⁷• The odds of successfully quitting at least doubles with the use of pharmacotherapy⁶• Minimizing out-of-pocket expenditures maximizes participation¹³

Value to Customers

The health and economic benefits of smoking cessation have been demonstrated for both payers and purchasers. Smoking cessation benefits can produce positive financial gains through reduced health care costs by reducing illness and death caused by smoking-related illnesses.⁸ MCOs are in a unique position to potentially reduce the burden of smoking across their covered populations. As with any disease management effort, a commitment of resources is necessary in order for realization of benefits to occur.

References

1. National Institutes of Health State-of-the-Science Conference Statement. Tobacco use: prevention, cessation, and control. Draft statement. June 14, 2006.
2. Centers for Disease Control and Prevention. Annual smoking-attributable mortality, years of potential life lost, and productivity losses – United States, 1997-2001. *Morb Mortal Wkly Rep.* 2005;54:625-628.
3. Centers for Disease Control and Prevention. Annual smoking-attributable mortality, years of potential life lost, and economic costs – US 1995-1999. *Morb Mortal Wkly Rep.* 2002;51:300-303.
4. Bunn WB, Stave GM, Downs KE, Alvir JM, Dirani R. Effect of smoking status on productivity loss. *J Occup Environ Med.* 2006;48:1099-1108.
5. Jarvis MJ. ABC of smoking cessation: why people smoke. *BMJ.* 2004;328:277-279.
6. Hughes JR. New treatments for smoking cessation. *CA Cancer J Clin.* 2000;50:143-151.
7. Centers for Disease Control and Prevention. Coverage for tobacco use cessation treatments: why, what, and how. Available at: http://www.cdc.gov/tobacco/educational_materials/cessation/ReimbursementBrochureFull.pdf. Accessed March 22, 2006.
8. Fiore MC. Preventing 3 million premature deaths—helping 5 million smokers quit: a national action plan for tobacco cessation. Subcommittee on Cessation and Interagency Committee on Smoking and Health. Final draft February 13, 2003.
9. Halpern MT, Dirani R, Schmier JK. Impacts of a smoking cessation benefit among employed populations. *J Occup Environ Med.* 2007;49:11-21.
10. Walker T. Managed care coverage for specific drug classes. *Managed Healthcare Executive.* March 1, 2006. Available at: <http://www.managedhealthcareexecutive.com/mhe/content/printContentPopup.jsp?id=311737>. Accessed June 26, 2006.
11. American Cancer Society. The cost of smoking to business. Available at: http://www.cancer.org/docroot/NWS/content/NWS_2_1x_The_Cost_of_Smoking_to_Business.asp. Accessed October 18, 2006.
12. Schroeder SA. What to do with a patient who smokes. *JAMA.* 2005;294:482-487.
13. Hopkins DP, Briss PA, Ricard CJ, et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *Am J Prev Med.* 2001;20(2S):16-66.