Tracking Comprehensive Cessation Coverage for Insured Populations

SURVEILLANCE & EVALUATION WEBINAR SERIES

OFFICE ON SMOKING AND HEALTH

OCTOBER 27, 2016

Presenters

Why Tracking Matters
Stephen Babb, MPH
Centers for Disease Control and Prevention

The Insurance Landscape: Implications for Tracking Coverage
Claire Brockbank, MS
Segue Consulting

Tobacco Cessation Policy: The Importance of Data Collection
Anne DiGiulio, BA
American Lung Association

Using Tracking to Build Partnerships and Improve Access to Cessation Assistance
Deb Osborne, MPH
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Why Tracking Matters

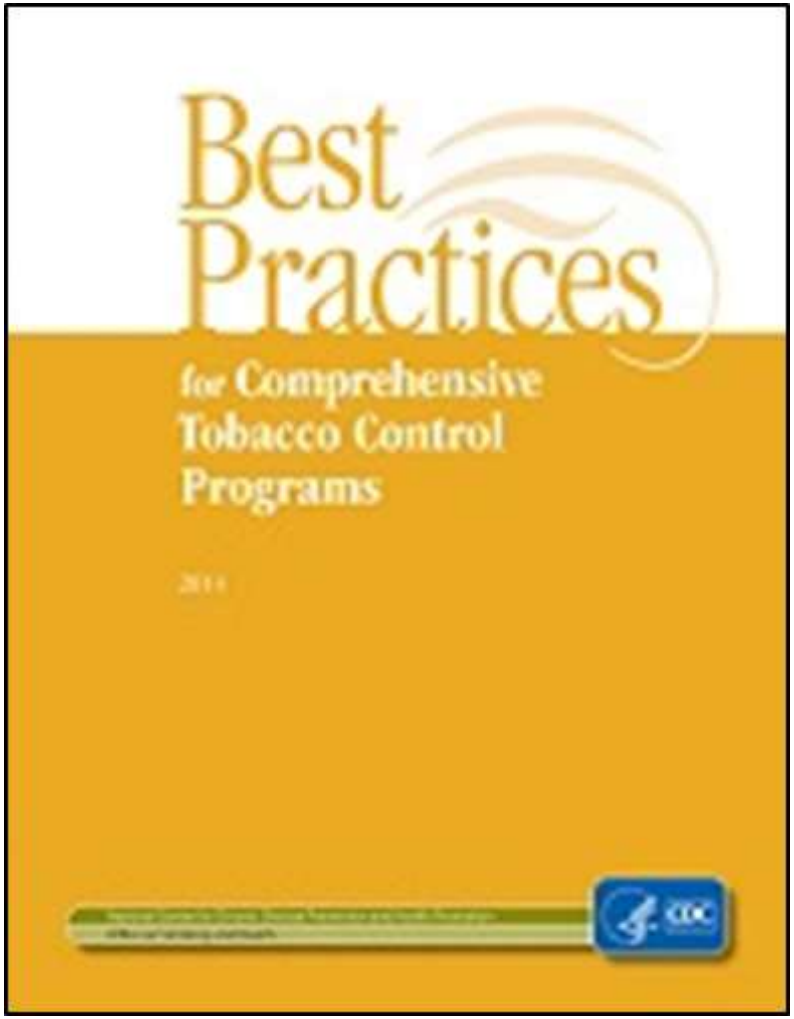
STEPHEN BABB, MPH

III. Cessation Interventions

3 Major Goals:

- Promoting health systems change
- Expanding insurance coverage and utilization of proven cessation treatments
- Supporting state quitline capacity

p. 41



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Tracking Comprehensive Cessation Coverage for Insured Populations

The Insurance Landscape: Implications for Tracking Coverage

Claire v.S. Brockbank

October 27, 2016

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Today's Presentation

- What is the landscape of private insurance and employer-sponsored health plans?
- How does this impact comprehensive cessation coverage?
- How does this impact your ability to access data to track coverage?

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Major Market Segments

- Private/Commercial
  - Group (employment-based)
  - Non-group Individual (direct purchase)
- Government
  - Medicare
  - Medicaid
  - Other government (VA, Tri-Care, etc.)

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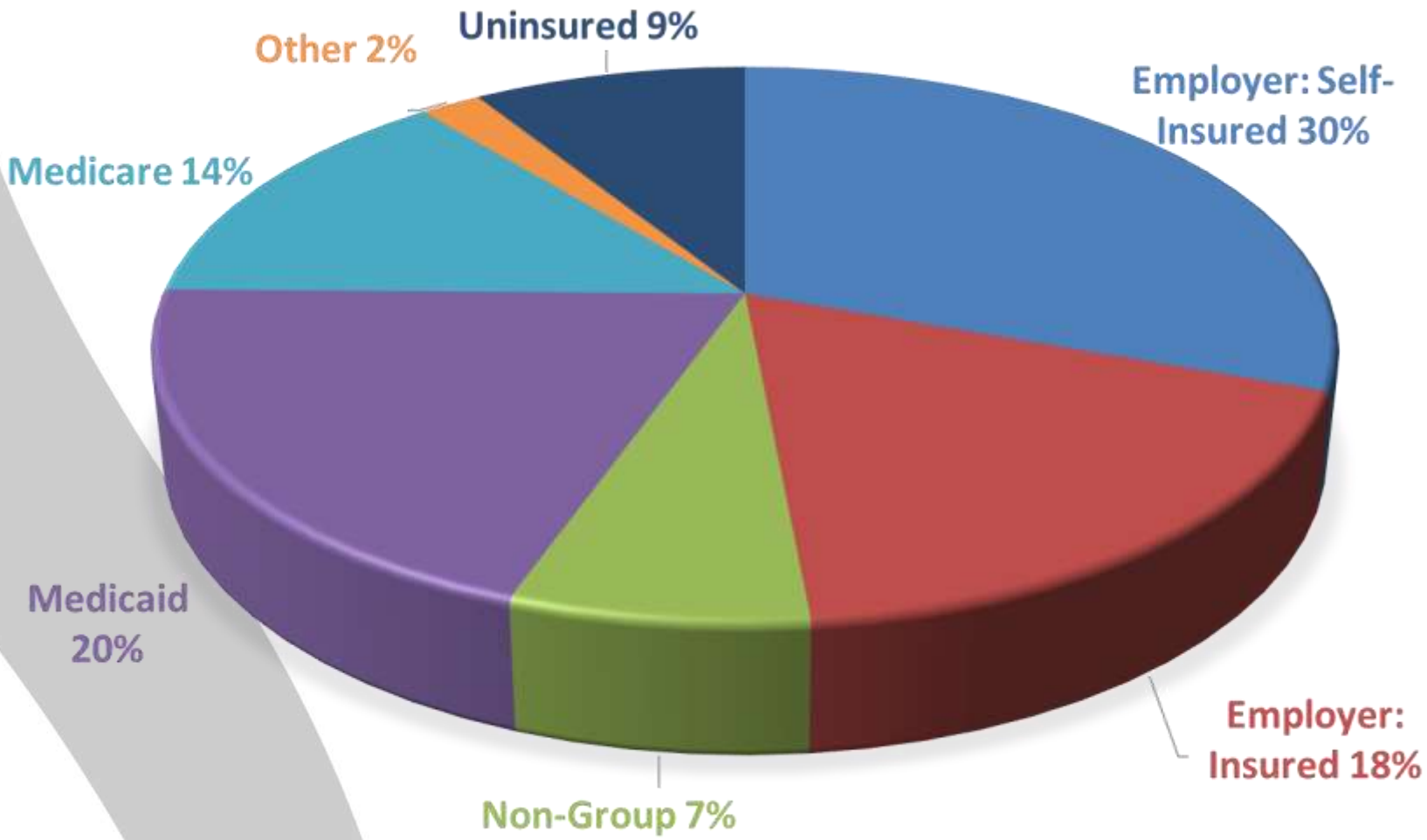
Sources of Coverage 2015



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Private/Commercial

- Key Players
  - Employers
  - Health Plans
- Key Differentiators
  - Insured versus self-insured
  - Size
  - Geographic presence

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Insured versus Self-Insured

- Insured
  - Employer pays premium
  - Health insurer assumes risk for cost of care
  - Premium tax + profit margin + risk embedded in premium
- Self-insured
  - Employer assumes risk for cost of care
  - Employer determines what benefits to cover and often has multiple entities – pharmacy, wellness, behavioral health
  - Health plan is paid an Administrative Services Only (ASO) fee for access to provider network, claims processing, reporting

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Regulatory Implications

- Insured plans
  - Regulated by State Insurance Commissioners
  - Plan design driven by state and federal requirements
    - Federal: maternity, mental health parity, ACA
    - State: state-by-state mandates
- Self-insured plans
  - Limited data reporting requirements
  - Plan design only impacted by federal requirements
  - Focal point is not ASO entity but employer

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Group Size

- Different rating and benefit coverage requirements for small versus large group
- Degree of reporting from health plans varies by size – even setting aside the issue of insured versus self-insured

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Geographic Presence

- Multi-state Employer
  - Coverage decisions typically made at corporate headquarters on behalf of all employees
  - Strong desire for uniformity, or at least equity
- National or Multi-state Health Plan
  - Decisions increasingly made at corporate headquarters
  - “Control” plan is based on employers’ corporate headquarters; local “participating affiliate” plan may not have access to data

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Comprehensive Cessation Coverage

- USPSTF recommendations set ACA requirements for insured AND self-insured groups
- Accountable party for providing required services
  - The health plan who sells the product or the employer who buys the product?
  - Is this different for insured versus self-insured employers?

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Accountability: Fully Insured

- The health plan is responsible for selling fully insured products that meet the requirements of the ACA
- If health plan outsources an ACA-required component of care, it must include those components in its rate filings to the state and is accountable for managing the service
- State insurance regulators have oversight

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Accountability: Self-Insured

- Employer bears ultimate responsibility but typically relies on the agent/consultant or ASO entity
- Federal regulators have oversight
- No centralized data repository or reporting requirements

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Tobacco Benefits Uniquely Fragmented

- Screening
  - Responsibility of the provider and no unique billing code for claims submission
- Pharmacotherapy
  - Formularies limited to prescription-based, not OTC
  - ALA experience is valuable example
- Counseling
  - Individual: Counseling reimbursement codes are available but not used extensively (multiple Dx codes with ICD-10)
  - Group: Biggest gap in coverage
  - Telephonic: Historic reliance on public health and/or external vendors (e.g. Ask a Nurse, Wellness vendor)

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Implications for Tracking Coverage

- Access to data for insured population easier than self-insured
- Multiple coverage providers (e.g. Rx, docs, external vendors) add complexity for tracking data
- Lack of consistent ACA interpretation regarding benefit requirements among state regulators, health plans, and employers raises a note of caution for multi-state analysis
- Don’t let perfect be the enemy of good

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Tobacco Cessation Policy: The Importance of Data Collection

October 27, 2016

Anne DiGiulio
Manager, Lung Health Policy
American Lung Association

What is a Comprehensive Cessation Benefit?

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Comprehensive Benefit

- 7 Medications
  - 5 NRTs (Gum, Patch, Lozenge, Nasal Spray, Inhaler)
  - Bupropion
  - Varenicline
- 3 Types of Counseling
  - Individual (face-to-face)
  - Group
  - Phone

Common Barriers to Access Care

- Cost Sharing (Co-Pays)
- Prior Authorization
- Stepped Care Therapy
- Required Counseling
- Duration Limits
- Annual (or Lifetime) Limits
- Dollar Limits

What should be covered?
(Affordable Care Act Requirements)

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Medicaid – Pregnant Women

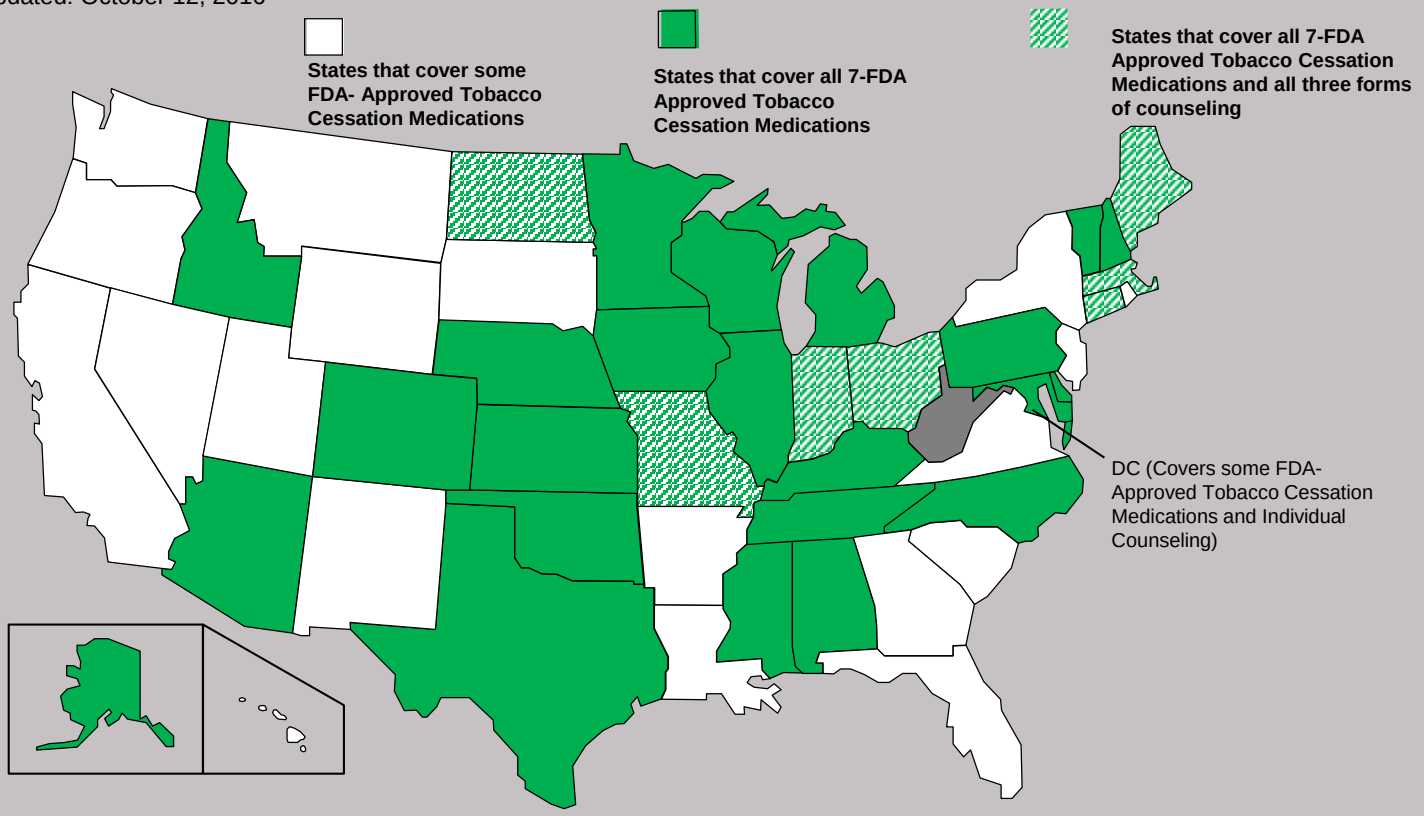
- 2010 ACA requirement
  - All pregnant women on Medicaid have access to all treatments with no cost sharing.
  - Written into the Law- Section 4107
  - Includes all FDA-approved pharmacotherapy and counseling

Traditional Medicaid

- Section 2502 of the Affordable Care Act removed tobacco cessation medications from the exclusions list.
- Counseling not addressed.
- Many States are still not covering all FDA-approved Medications.
- Does allow states to still charge a co-pay and erect other barriers to accessing care?

Traditional Medicaid Coverage for Tobacco Cessation Counseling and Medications

Last updated: October 12, 2016



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USPSTF Recommendation

- ACA requires most private plans, including any plan sold on the exchange and Medicaid Expansion plans, to cover all services given an ‘A’ or ‘B’ grade by USPSTF to be covered without cost-sharing.
- Tobacco Cessation receives an ‘A’ grade for all adults for both counseling (all three forms) and pharmacotherapy (all 7 FDA-approved medications).

Cessation Guidance FAQ

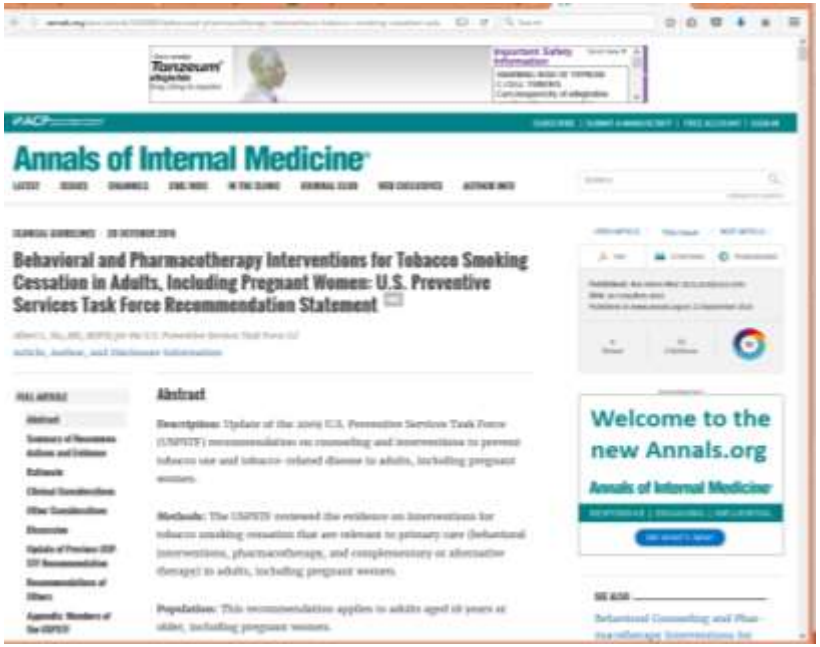
- On May 2, 2014 the Departments of Labor, Treasury and Health and Human Services issues a FAQ questions on how the tobacco cessation recommendation should be implemented.

- Tobacco Cessation Guidance
  - At least 4 sessions of individual, group and phone counseling
  - At least 90 days of all FDA-approved smoking cessation medications, when prescribed
  - At least 2 quit attempts per year
  - No cost-sharing
  - No prior authorization

Q5

September 2015 USPSTF Updated Cessation Recommendation

- In September 2015, the USPSTF updated their recommendation, reaffirming the “A” grade for tobacco cessation.
- Found that both counseling and pharmacotherapy are effective to help smokers quit.



Tobacco Surcharges

- Variation in insurance premiums based on a policyholder's tobacco use
- Also referred to as tobacco premiums, premium/rate differentials, non-smoker discounts
- ACA allows surcharges of up to 50% for tobacco use in group & individual markets
- States can limit or prohibit the surcharge

Data Collection: Lessons Learned

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Lung Association's History of Data Collection

- Collected Medicaid coverage data for the last 9 years.
- Collected State Employee Health Plan coverage for the past 6 years.
- In 2013, the Lung Association became the official source of data for the Centers for Disease Control and Prevention
- Coverage is confusing – different people will have different answers. (Always need it in writing)

Things to Remember!

- No shortcuts- just keep digging.
- Public information can be conflicting.
- Verify public information is accurate.

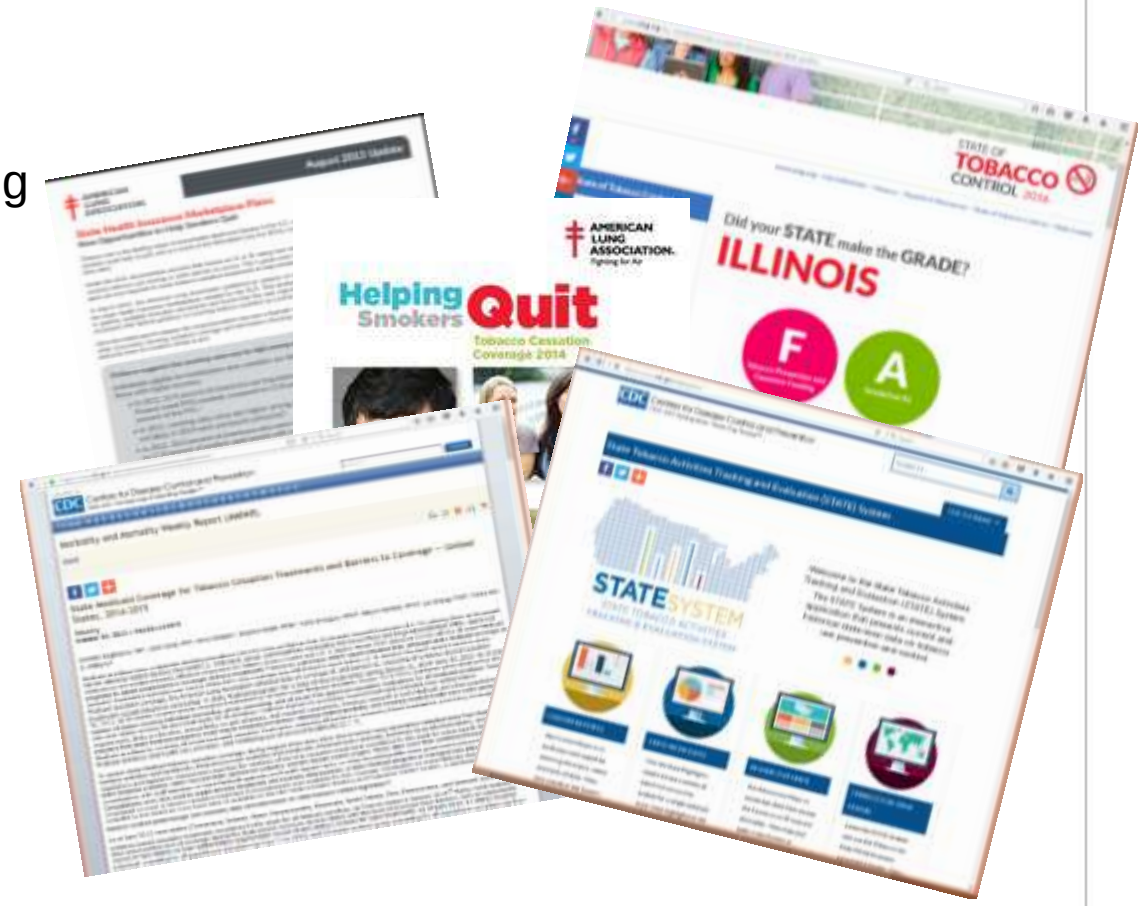
Lessons Learned

- Decide what data is important to collect.
- Key Questions to Ask:
  - What does coverage mean?
  - What barriers are important to collect?
  - Will you be repeating your process on an annual basis?
  - How detailed of data are you going to collect?
  - Are you going to publish your data?
  - Is it feasible to collect the data you want?

How the Data is Being Used

Data Collection

- Shows what progress is being made.
- Shows where gaps remain.
- Public reports
  - State of Tobacco Control
  - STATE System
  - MMWR Articles
  - Helping Smoker Quit
  - Exchange report
- What will you use your data for?



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Using Tracking to Build Partnerships to Improve Access to Cessation Assistance

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October 2016

NAQC Public-Private Partnership Initiative

Goal: To increase the number of private and public insurers that provide comprehensive tobacco cessation coverage and utilize evidence-based treatment services, including quitlines.

Participating States: Arizona, Florida, Kentucky, Maryland, Massachusetts, New Hampshire, North Carolina, Rhode Island, Utah and Washington

Overall State Assessment

- State tobacco rates, # of tobacco users
- Quitline services, budget, pop. served
- Quitline reach and utilization by insurer type
- Insurance distribution – private and public
- eValue8 and Hedis scores
- Large employers and insurance carriers
- Medicaid distribution – FFS and MCOs
- State legislation and support

Worksheet - http://www.naquitline.org/?page=ResourceCenter

Private and Public Insurers

- State as an employer
- Medicaid – FFS and MCOs
- Large health plans
- Large employers
  - City/County Municipalities
  - Universities

Assessment Tools

Tailored to State's Needs

- Cessation Specific
- Worksite Wellness – SHS Policy and Cessation Coverage
- State Legislation and ACA Implementation
- MCO Cessation Coverage
- State Employee Plans- Cessation Assessment Grid

Resources - http://www.naquitline.org/?page=ResourceCenter

Assessing Coverage: Getting Started

- Determining priority areas, tools, approach
  - Staff time; how will the information be used
- Identifying appropriate contact
  - Medical director, QI director, Wellness director
- Overcoming health plan/employer “belief” they offer comprehensive coverage
- Improving insurer’s commitment to complete the assessment

Assessing Coverage: State Approaches

- Kentucky – Engaged underwriters
- Florida – Utilized University and community grantees
- Rhode Island – Legislatively mandated
- Utah – Capitalized on Business Summit
- Massachusetts – Utilized state experts and state employees
- Colorado – Partnered with the Association of Health Plans

Kentucky – Engaging Underwriters

Tool: Survey

Method: In-person and phone

Approach: Relationships built on education

- Met with underwriters one-on-one;
- State Underwriter's Conference
- In-roads to meeting health plan representatives

Lesson Learned: On-going relationships and education key to success; time consuming though beneficial

Florida – State and Community Level

Tool: Interview and Worksite Wellness Survey

Method: Contracted with University for health plans/employer assessments and local grantees assess employers at the community level

Approach: University cold calls; local grantees integrate SHS policy and cessation coverage

Lessons Learned: Completion rate low at state level and no on-going relationship; community level SHS policy and coverage natural fit, education opportunity; Awards Program good motivator

Rhode Island – Legislatively Mandated

Tool: Survey developed in collaboration with health plans

Method: Mailed; support via tobacco council

Approach: Legislative mandated for fully-insured to report benefit utilization annually; incorporated coverage assessment

Lessons Learned: complicated by multiple products; assessment annually maintains relationship; legislation does not include self-insured

Massachusetts – Contracted Services

Tool: Interview Guide

Method: In-person

Approach: Contracted w/company that had established relationships w/plans

Lessons Learned: Lost opportunity to build relationships; no on-going communication; very effective in getting assessment completed

Massachusetts: State Employee Plans

Tool: Cessation Assessment Grid

Method: Phone and web-based information

Approach: Utilized state staff to contact different insurers to identify coverage

Lessons Learned: Insurer more likely to share benefits with plan member; demonstration of inequity of coverage among plans a strong motivator to improve benefit; timing is key – benefits procurement

Utah – Business Summit

Tool: One-page Assessment

Method: Mail prior to Business Summit

Approach: Completion of assessment allowed for promotion of plan's benefits at the Summit

Lessons Learned: Helping plans understand "what is in it for them" can help with higher completion rates. One-page assessment doable.

Colorado – Assoc. of Health Plans

Tool: State and ACA Legislation Survey

Method: Mailed and Follow-up Interviews

Approach: Request form Association of Health Plans and Health Department Medical Director

Lessons Learned: Partnering with Assoc. of HP key to high completion rate and follow-up interviews helped to verify benefits and build relationships

Lessons Learned

- Tailor assessment
- It is not a research study
- Relationships key to completion
- Opportunity to educate on evidence-based cessation coverage and resources
- Key staff need to participate in survey process to establish on-going relationships
- Completion rates improve when insurers understand the benefit to them

Resources

Assessment Tools:

http://www.naquitline.org/?page=ResourceCenter

State Contacts and Promising Practices Report:

http://www.naquitline.org/?page=PPPStateBriefs

Public-Private Partnership Initiative:

http://www.naquitline.org/?page=PPP

Discussion

Thank you!

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.