Smoking-related diseases afflict more than 16 million Americans and contribute to nearly 500,000 deaths annually, making tobacco the nation’s leading cause of preventable death and disease.

The financial toll is also high—an estimated $132 billion is spent annually on health care expenses to treat smoking-related diseases, much of it borne by the states. In an effort to reduce both the human and financial costs, many state policymakers are pursuing programs proven to help smokers quit, especially among Medicaid recipients, whose smoking rates are higher than the general population’s. A 2009 study published in Preventing Chronic Disease found that smoking-related illnesses account for 11 percent of Medicaid expenditures, or nearly $22 billion annually.

The most effective stop-smoking programs combine medication and individual and/or group counseling, according to the Centers for Disease Control and Prevention (CDC). Using medication alone, about 25 percent of quitters remain smoke-free for more than six months. Due to nicotine’s addictive properties, only 4 percent to 7 percent of attempts to quit are successful without some form of help. The U.S. Food and Drug Administration (FDA) has approved seven types of over-the-counter or prescription medication for tobacco cessation: over-the-counter nicotine gum, lozenges and patches, and prescription nicotine nasal sprays and oral inhalers, all designed to wean smokers off tobacco by gradually reducing their craving; and two non-nicotine medications.

Federal Action
In 1964, the Surgeon General’s office released the first of more than 30 subsequent reports linking smoking to disease. The Affordable Care Act (ACA) contains a number of provisions specific to tobacco-cessation programs. Among them, most new private health insurance plans must cover preventive services given an “A” or “B” rating by the U.S. Preventive Services Task Force, including tobacco-cessation treatments, with no cost sharing. States must choose their own benchmarks for coverage and determine which cessation treatments are covered.

The ACA also creates new cessation requirements specific to Medicaid coverage. For instance, state Medicaid programs must cover the full cost of counseling and FDA-approved prescription and over-the-counter stop-smoking drugs for pregnant women. The ACA also prohibits state Medicaid programs from excluding coverage of FDA-approved tobacco cessation medications for all enrollees.
In 2011, a comprehensive tobacco-cessation benefit was added to the Federal Employee Health Benefits program. This coverage includes individual, group and telephone counseling for two quit attempts per year, including four counseling sessions per attempt, and all seven FDA-approved types of cessation medication. These benefits must be provided with no copayments or coinsurance, and are not subject to deductibles or annual or lifetime dollar limits.

State Action
States and territories have taken a variety of approaches to encourage quitting tobacco use, including targeting Medicaid enrollees and state employees.

Medicaid. Roughly 37 percent of adult Medicaid enrollees smoke, compared to about 19 percent of all adults over age 18. Therefore, reducing tobacco use in the Medicaid population could cut state Medicaid costs. According to the CDC, seven states cover individual counseling, group counseling and all seven FDA-approved medications for all Medicaid enrollees: Connecticut, Indiana, Massachusetts, Minnesota, Nevada, Pennsylvania and Vermont. The most common barriers to accessing the treatments are limits on the duration and extent of treatment coverage, copayments and prior authorization requirements.

Since 2006, Massachusetts’ Tobacco Cessation and Prevention Program has allowed Medicaid beneficiaries to obtain FDA-approved smoking cessation drugs with a copayment of $1 to $3 and up to five free counseling sessions from the state’s telephone quit line. A 2010 evaluation of the program found that about 37 percent of smokers enrolled in Medicaid used the benefit after the state promoted it, and that participants’ rates of hospital admissions for heart attacks, heart diseases and non-specific chest pain declined significantly. The study also found that the smoking rate among Medicaid beneficiaries decreased from 38 percent to 28 percent during the program’s first two and a half years. A 2012 study of the program found that each $1 spent on medication, counseling, promotion and outreach was associated with an average reduction of $3.12 in Medicaid expenditures for cardiovascular admissions to hospitals.

State Employees. State government is the largest employer in many states, and all states offer some form of stop-smoking treatment in employee health plans. This coverage can lead to savings for states. Six months after the Oklahoma State Department of Health began offering stop-smoking programs to state employees, an estimated 570 workers had kicked the habit. Workers were given the option of two 90-day courses of any FDA-approved prescription tobacco-cessation product each year and access to the Oklahoma Tobacco Helpline to work with a personal quit coach. The state estimated it saved $2.2 million annually, or roughly $3,800 per successful quitter, through reduced health care costs and increased employee productivity.

NCSL Contact and Resources
Karmen Hanson
NCSL—Denver
(303) 856-1423

Tobacco and Smoking
Tobacco Cessation

Additional Resources
Centers for Disease Control and Prevention, Best Practices for Comprehensive Tobacco Control Programs, 2014
Public Health Law Center, How the Affordable Care Act Affects Tobacco Use and Control

The information contained in this LegisBrief does not necessarily reflect NCSL policy.