What is already known about this topic?

Medicaid enrollees smoke cigarettes at a higher rate than do privately insured U.S. residents. States that expand Medicaid eligibility are able to extend coverage to large numbers of adult smokers who are not eligible for traditional Medicaid cessation coverage, thereby substantially increasing the potential impact of Medicaid cessation coverage.

What is added by this report?

By expanding Medicaid eligibility under the Affordable Care Act, 32 states have extended Medicaid cessation coverage to about 2.3 million adult smokers who were not previously eligible for Medicaid. All 32 of these states covered some cessation treatments for all Medicaid expansion enrollees. Nine states covered all nine cessation treatments considered in this study for all Medicaid expansion enrollees, and 19 states covered all seven FDA-approved cessation medications for all enrollees. All 32 states imposed one or more barriers to accessing at least one cessation treatment for at least some enrollees.

What are the implications for public health practices?

States that have expanded Medicaid can take further steps to help smokers quit by covering proven cessation treatments more fully, removing barriers to accessing covered treatments, making Medicaid enrollees and their health care providers aware of these treatments, and monitoring use of these treatments.

In 2015, 27.8% of adult Medicaid enrollees were current cigarette smokers, compared with 11.1% of adults with private health insurance, placing Medicaid enrollees at increased risk for smoking-related disease and death. In addition, smoking-related diseases are a major contributor to Medicaid costs, accounting for about 15% (> $39 billion) of annual Medicaid spending during 2006–2010. Individual, group, and telephone counseling and seven Food and Drug Administration (FDA)-approved medications are effective treatments for helping tobacco users quit. Insurance coverage for tobacco cessation treatments is associated with increased quit attempts, use of cessation treatments, and successful smoking cessation; this coverage has the potential to reduce Medicaid costs. However, barriers such as requiring copayments and prior authorization for treatment can impede access to cessation treatments. As of July 1, 2016, 32 states (including the District of Columbia) have expanded Medicaid eligibility through the Patient Protection and Affordable Care Act. Medicaid enrollees smoke cigarettes at a higher rate than do privately insured U.S. residents. States that expand Medicaid eligibility are able to extend coverage to large numbers of adult smokers who are not eligible for traditional Medicaid cessation coverage, thereby substantially increasing the potential impact of Medicaid cessation coverage.

By expanding Medicaid eligibility under the Affordable Care Act, 32 states have extended Medicaid cessation coverage to about 2.3 million adult smokers who were not previously eligible for Medicaid. All 32 of these states covered some cessation treatments for all Medicaid expansion enrollees. Nine states covered all nine cessation treatments considered in this study for all Medicaid expansion enrollees, and 19 states covered all seven FDA-approved cessation medications for all enrollees. All 32 states imposed one or more barriers to accessing at least one cessation treatment for at least some enrollees.

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With regard to tobacco cessation coverage, Medicaid expansion coverage is subject to different ACA provisions than traditional Medicaid coverage. In Massachusetts, an evidence-based, heavily promoted Medicaid cessation benefit was associated with a reduction in smoking prevalence, from 38.3% to 28.3% over a 3-year period. Massachusetts, an evidence-based, heavily promoted Medicaid cessation benefit was associated with a reduction in smoking prevalence, from 38.3% to 28.3% over a 3-year period. For each dollar spent on the benefit over a 3-year period, an estimated $3.12 in medical savings occurred from averted cardiovascular hospitalizations alone.

A Healthy People 2020 objective (TU-8) calls for all state Medicaid programs to adopt comprehensive coverage of smoking cessation treatments. A previous study reported on state Medicaid cessation benefit enrollment data for December 2015. Newly eligible Medicaid enrollees were defined as persons who were newly enrolled in Medicaid because of ACA Medicaid expansion. Some states expanded Medicaid eligibility to varying extents before ACA was enacted. The overall Medicaid expansion population estimates include persons who enrolled in Medicaid because of these previous state expansion actions, as well as persons who enrolled in Medicaid because of state Medicaid expansions under ACA. The newly eligible Medicaid population estimates include the latter group only.

To assess cessation coverage available to the state Medicaid expansion population as of July 1, 2016, the American Lung Association collected data on coverage of, and barriers to accessing, all evidence-based cessation treatments except telephone counseling (a total of nine treatments) for state Medicaid expansion populations. The American Lung Association compiled data from Medicaid member websites and handbooks; Medicaid provider websites and handbooks; policy manuals; plan formularies and preferred drug lists; Medicaid state plan amendments; and relevant regulations and legislation. Personnel from state Medicaid agencies and health departments or other state government agencies were consulted to confirm the accuracy of collected information, retrieve missing documents, and reconcile discrepancies. Data were collected during July 19–August 18, 2016.

As of December 2015, approximately 3.3 million adult cigarette smokers were enrolled in Medicaid expansion coverage, including approximately 2.3 million adults who were newly eligible for Medicaid expansion coverage (Table 1). The number of adult smokers enrolled in Medicaid expansion coverage ranged from 2,567 in Alaska to 618,395 in New York; the number of newly eligible adult smokers enrolled in this coverage ranged from 2,567 in Alaska to 291,351 in Pennsylvania (Table 1).

As of July 1, 2016, nine of the 32 states that have expanded Medicaid eligibility (Colorado, Connecticut, Indiana, Massachusetts, Minnesota, North Dakota, Ohio, Pennsylvania, and Vermont) covered all nine cessation treatments for all Medicaid expansion enrollees (Table 2). Of the 32 states, 17 states covered individual counseling for all Medicaid expansion enrollees, 11 covered group counseling for all enrollees, and 19 covered all seven FDA-approved cessation medications for all enrollees. All 32 states imposed at least one barrier (e.g., copayments or prior authorization) on at least one treatment for at least some enrollees (Table 3). Six states required copayments for at least one cessation treatment for all enrollees, with an additional seven states requiring copayments for some enrollees. Twelve states required prior authorization to obtain at least one cessation treatment for all enrollees, with an additional 14 states requiring prior authorization for some enrollees.

### Discussion

Under the Medicaid expansion provision of ACA, states can expand Medicaid eligibility to include adults aged ≤65 years with incomes ≤138% of the Federal Poverty Level. As of July 1, 2016, 32 states have expanded Medicaid eligibility, a step which has made Medicaid cessation coverage available to approximately 2.3 million adult smokers who were not previously eligible for Medicaid. Moreover, all of these states covered some cessation treatments for all Medicaid expansion enrollees, and 19 states covered all seven FDA-approved cessation medications for all enrollees. However, only nine states covered all nine cessation treatments, and all 32 states imposed one or more barriers to accessing cessation treatments for at least some enrollees. Several states, including Michigan and Minnesota, have made notable progress in removing barriers to cessation coverage for both their expansion and traditional (i.e., nonexpansion) Medicaid populations in recent years. Other states have made more recent progress in this regard. For example, Maryland removed copayments for cessation medications for enrollees in both expansion and traditional Medicaid, effective October 21, 2016. In September 2016, California enacted legislation requiring the state Medicaid program to cover a comprehensive cessation benefit for both the expansion and traditional Medicaid populations, effective January 1, 2017. Providing and promoting evidence-based cessation coverage has been found to be a cost-effective way to help smokers quit. Among the Medicaid population in Massachusetts, an evidence-based, heavily promoted Medicaid cessation benefit was associated with a reduction in smoking prevalence, from 38.3% to 28.3% over a 3-year period. For each dollar spent on the benefit over a 3-year period, an estimated $3.12 in medical savings occurred from averted cardiovascular hospitalizations alone.
More comprehensive state Medicaid coverage of cessation treatments is associated with increased use of cessation medications and increased quit rates among smokers enrolled in Medicaid (Δ&8). Moreover, removing barriers such as copayments, which pose a financial obstacle, and prior authorization, which can delay accessing services unless a process is in place to expedite authorization, further increases access to these treatments (2,5). Communicating to smokers and health care providers that cessation treatments are covered is also important to ensure that they are aware of and use covered treatments (5,7). A recent study found that only approximately 10% of Medicaid enrollees who smoked received a prescription for a tobacco cessation medication in 2013, with wide variation in use of cessation medications across states (10). Medicaid cessation coverage has the greatest effect when it is available to large numbers of smokers and is widely used (5,7).

The findings in this report are subject to at least four limitations. First, enrollment estimates were drawn from a new CMS reporting system whose primary purpose is to allow states to claim the enhanced Medicaid expansion federal matching rate; this system was missing information for seven expansion states for the assessment period. Second, the state smoking prevalence estimates were based on respondents who reported that they smoked and were enrolled in Medicaid; these estimates were not available for three states, and the relevant BRFSS question did not distinguish between traditional and Medicaid expansion coverage. In addition, 2014 smoking prevalence estimates were applied to December 2015 enrollment data to generate estimates of smokers enrolled in Medicaid expansion. Third, in cases where official coverage documents were not publicly available, were outdated, or conflicted with one another, state government personnel were consulted to provide additional documentation or resolve discrepancies; this information might be inaccurate in some cases. Finally, cessation coverage can vary widely across Medicaid expansion managed care plans, making it challenging to determine coverage.

The 32 states that have expanded Medicaid eligibility under ACA are providing Medicaid cessation coverage to approximately 2.3 million adult smokers who were not previously eligible for Medicaid. These states can take further steps toward helping these smokers quit by more fully covering cessation treatments, removing barriers to accessing covered treatments, making Medicaid enrollees and providers aware of these treatments, and monitoring use of these treatments (2,5–7). State Medicaid programs that take these actions can substantially reduce tobacco use and tobacco-related disease and health care costs among a vulnerable population (4–7). Opportunities exist for the 19 states that have not expanded Medicaid eligibility to reduce smoking among low-income adults by making their cessation coverage more broadly available. Providing barrier-free access to cessation treatments and promoting their use are important components of a comprehensive approach to reducing tobacco use (3,5–7).

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† Coverage for the adult expansion population must be offered through an alternative benefit plan. States generally have expanded coverage in one of two ways: by extending traditional Medicaid coverage to the Medicaid expansion population or by creating a benefit package that is not aligned with the state’s traditional Medicaid state plan and using managed care for the expansion population. States can also provide subsidies to this population that are used to purchase coverage offered in the state or federally facilitated marketplace created by the Patient Protection and Affordable Care Act.
‡ Data were obtained from the Behavioral Risk Factor Surveillance System (BRFSS) 2014 health care access module (http://www.cdc.gov/brfss/). Smoking prevalence estimates were calculated for 2014 BRFSS respondents aged 18–64 years who reported the following: 1) smoking ≥100 cigarettes during their lifetimes and smoking every day or some days at the time of the interview, and 2) having Medicaid or another state program as the primary source of their health care coverage. The relevant BRFSS question did not distinguish between traditional and expansion Medicaid coverage.

Telephone cessation counseling is available free to callers to state quitlines (including Medicaid enrollees) in all 50 states and the District of Columbia through the national quitline portal 1-800-QUIT-NOW, and therefore is not included in this report. In June 2011, the Centers for Medicare & Medicaid Services (CMS) announced that it would offer a 50% federal administrative match to state Medicaid programs for the cost of state quitline counseling provided to Medicaid enrollees. Although not discussed in this report, some state Medicaid programs cover or otherwise provide access to telephone counseling for at least some Medicaid enrollees.

Although a June 2012 Supreme Court ruling held that a state cannot lose federal funding for its existing Medicaid program if it does not participate in the expansion, financial incentives exist for all states to expand eligibility for Medicaid coverage (National Federation of Independent Business, et al. v. Kathleen Sebelius, Secretary of Health and Human Services, et al.; 132 S. Ct. 2566 [2012]).


### References

10. Ku L, Bruen BK, Steinmetz E, Bysshe T. Medicaid tobacco cessation: big gaps remain in efforts to get smokers to quit. Health Aff (Millwood) 2016;35:62–70. [CrossRef] [PubMed]

### TABLE 1. Estimated number of current smokers aged 18–64 years in Medicaid Expansion—32 states,* December 2015

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<th>State</th>
<th>Estimated Number of Current Smokers</th>
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**Abbreviations**: NA = not available; NR = not reported.

* Includes the District of Columbia.
§ The total VIII group category includes persons who enrolled in Medicaid because of actions in some states that expanded Medicaid eligibility before...
enactment of the Patient Protection and Affordable Care Act (ACA) and persons who enrolled in Medicaid because of state Medicaid expansions under ACA. The total VIII group newly eligible category only includes the latter group.

Data were obtained from the Behavioral Risk Factor Surveillance System (BRFSS) 2014 health care access module (http://www.cdc.gov/brfss). Smoking prevalence estimates were calculated for 2014 BRFSS respondents aged 18–64 years who reported: 1) smoking ≥100 cigarettes during their lifetimes and smoking every day or some days at the time of the interview, and 2) having Medicaid or another state program as the primary source of their health care coverage. The relevant BRFSS question did not distinguish between traditional and expansion Medicaid coverage. Although one decimal point prevalence estimates are reported here, two decimal point prevalence estimates were used in calculating the total and newly eligible numbers of smokers in the VIII group.

**BRFSS smoking prevalence estimates from 2014 were applied to December 2015 enrollment data to generate estimates of smokers with expansion Medicaid coverage. Although one decimal point prevalence estimates are reported here, two decimal point prevalence estimates were used in calculating the total and newly eligible numbers of smokers in the VIII group.**

**TABLE 2. Medicaid expansion coverage of tobacco cessation treatments — 32 states,* July 1, 2016**

**TABLE 3. Barriers to Medicaid expansion coverage of tobacco cessation treatments — 32 states,* July 1, 2016†**

**Abbreviations:** NA = not available; V = varies by plan.
* Includes the District of Columbia.
To monitor trends in state Medicaid cessation coverage, the American Lung Association collected data on coverage of all evidence-based cessation treatments except telephone counseling by state Medicaid programs (for a total of nine treatments), as well as data on barriers to accessing these treatments (such as charging copayments or limiting the number of covered quit attempts) from December 31, 2008, to January 31, 2014. As of 2014, all 50 states and the District of Columbia cover some cessation treatments for at least some Medicaid enrollees, but only seven states cover all nine treatments.

State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage - United States, 2016. Anne DiGiulio, Meredith Haddix, +5 authors Brian S. Armour. MMWR. In 2015, 27.8% of adult Medicaid enrollees were current cigarette smokers, compared with 11.1% of adults with private health insurance, placing Medicaid enrollees at increased risk for... (More).