Key Elements of a Model Tobacco Use Treatment Benefit

The following are key elements that need to be considered and that should guide decision makers in their deliberations about how to design an optimal tobacco use treatment benefit for their employees, their customers, the beneficiaries they serve, or the lives they cover through health insurance/health plan relationships with business and government.

- All benefit elements must be consistent with the recommendations and conclusions of major evidence-based reviews for tobacco use treatment (or any subsequent updates to these documents/literature reviews), including: (a) Treating Tobacco Use and Dependence: A Clinical Practice Guideline (*http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.7644*), (b) the U.S. Preventive Services Task Force (*http://www.ahrq.gov/clinic/uspstf/uspstbac.htm*), (c) the World Health Organization/Society for Research on Nicotine and Tobacco's tobacco use treatment database (*www.treatobacco.net*), (d) the Cochrane Collaboration (*http://www.cochrane.org/reviews/en/topics/94.html*), (e) the U.S. Center for Disease Control and Prevention's Community Preventive Services Task Force (*http://www.thecommunityguide.org/tobacco/default.htm*), and (f) the National Action Plan for Tobacco Cessation (*http://www.ctri.wisc.edu/Researchers/NatActionPlan%2002-04.pdf*).
- Tobacco use needs to be assessed and addressed in every clinical setting and visit.
- There should be ready access to evidence-based counseling services, including individual, group and phone counseling services, ensuring patients multiple options for treatment.
- There should be ready access to all U.S. Food and Drug Administration (FDA) approved tobacco use treatment medications, including prescription and over-the-counter products.
- While strongly recommended, there should be no requirement of participation in a formal counseling program as a precondition for gaining access to a medication benefit.
- Patient out-of-pocket treatment costs should be reduced or eliminated (to improve access).
- Since most tobacco users make multiple quit attempts before successfully quitting, tobacco treatment services should be available for multiple episodes of treatment per year and there should be no lifetime limit or limit to a single benefit year (this is in recognition of the pattern of addiction and relapse associated with tobacco use dependence).
- If targeting the benefit (e.g., to pregnant smokers), the benefit should be tailored to the unique needs of that population (e.g., if pregnant then use more intensive/frequent counseling and medications as a second line treatment after risks/benefits assessed by provider/patient).
- There should be a recognition that a variety of clinicians, not just physicians, provide the bulk of tobacco treatment services (particularly in rural and/or underserved areas), and eligibility for reimbursement therefore needs to be reflective of this situation.
- Reimbursement to providers for tobacco use treatment services must be adequate to cover the reasonable costs of delivering the benefit.
- There is a need to expand the number of trained tobacco use treatment providers through recognized and qualified training programs.
- There is a need for sustained education/promotional campaigns to raise awareness of benefits and to encourage utilization (among health systems, providers and consumers).
- There is a need for the collection of key data elements to monitor treatment and benefit use consistent with existing Health Plan Employer Data and Information Set (HEDIS) and National Committee for Quality Assurance (NCQA) requirements specific to tobacco use and for the purposes of evaluating the population and individual-level impacts of the benefit.

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