AMERICAN LUNG ASSOCIATION®
Fighting for Air

Helping Smokers Quit

Tobacco Cessation Coverage 2014

Helping Smokers Quit

Introduction

Fifty years ago, the first Surgeon General's Report on smoking and health was published. This landmark report spurred public health advocates and policymakers to action, starting a movement to prevent tobacco use and its harmful effects on our country.

Recognizing that most tobacco users start as kids or teenagers, much of the tobacco control movement has been focused on preventing youth from starting. In addition to preventing tobacco use, the American Lung Association has also been committed to helping smokers quit for more than 30 years. While overcoming an addiction to nicotine remains difficult for most people, research continues to emerge about the most effective ways to help smokers quit—including the Food and Drug Administration (FDA)-approved medications and counseling proven to help smokers when they are trying to quit.

The 2014 Surgeon General's report concluded that today's cigarette is more deadly and addictive than ever—which makes it even more vital for tobacco users to get the help they need to quit for good.[1]

NOW is the time for policymakers, insurance plans and employers to help smokers quit.

The American Lung Association's "Helping Smokers Quit 2014" highlights why it is so important that smokers have help to end their nicotine addiction. 2014 has been a watershed year for healthcare in America. Many of the major provisions of the Patient Protection and Affordable Care Act (ACA) went into effect on January 1, 2014, including new health insurance options for Americans who were previously uninsured. As policymakers, insurance plans and employers continue to implement this hallmark law, it is crucial they take every opportunity to give smokers easy access to the treatments that will help them quit.

- Every smoker needs access to a comprehensive tobacco cessation benefit
- Quit smoking treatments must be provided at no cost and be easy to access
- Insurance plans and employers should publicize what treatments are available and how to access them

Helping smokers quit saves lives and money

Quitting smoking improves a smoker's health immediately, but the most important health benefits are long term. A smoker who quits considerably reduces his or her risk for diseases like chronic obstructive pulmonary disease (COPD, which includes emphysema and chronic bronchitis), heart disease, lung cancer and many other cancers.[2] Life expectancy for current smokers is more than 10 years shorter on average than nonsmokers.[3] Some benefits of quitting cannot be quantified—like the benefit of living long enough to see a grandchild born or enjoying a long and healthy retirement.

Helping smokers quit not only saves lives—it also saves money. These savings come from lower healthcare costs, increased workplace productivity and averted premature deaths. Studies indicate that helping smokers quit saves thousands of dollars in healthcare expenditures per smoker.[4,5] Studies have also demonstrated that helping smokers quit is a smart, money-saving investment.[6] A 2012 study by George Washington University showed that when the Massachusetts Medicaid program covered a comprehensive tobacco cessation benefit, the state saw a 3-to-1 return on investment in just the first 18 months alone.[7]

What Works to Help Smokers Quit?

While most smokers want to quit and many of them try every year, only a relatively small percentage are successful.[8] A 2010 Centers for Disease Control and Prevention (CDC) study showed that 69 percent of adult smokers wanted to stop smoking, 52 percent had tried to do so in the past year and only 6 percent had recently quit.[9] Many tobacco users require several attempts before they quit for good, and many need help during the quitting process.[10] Quitting "cold turkey" is not effective for the vast majority of smokers.[11] Fortunately, a number of treatments exist that are proven to increase a smoker's chances of quitting for good.

Cessation Benefits Should Include ALL of These Treatments:

MEDICATIONS	COUNSELING
✔ Nicotine Gum	✔ Individual
✔ Nicotine Patch	✔ Group
✔ Nicotine Lozenge	✔ Phone
✔ Nicotine Inhaler	
✔ Nicotine Nasal Spray	
✔ Bupropion	
✔ Varenicline	

The U.S. Public Health Service's 2008 Clinical Practice Guideline Update Treating Tobacco Use and Dependence[12] recommends the seven FDA-approved prescription and over-the-counter medications and three types of counseling that have proven effective in helping smokers quit. The guideline is a review of decades of research on tobacco cessation and is widely regarded as the definitive resource on effectively treating tobacco users.

Making it Easy for Smokers to Get Help

Beyond covering the right evidence-based treatments, insurance plans and employers must:

1. Make it as easy as possible for smokers to use treatment

To the greatest extent possible, insurance/health plans should remove policies that create barriers to smokers getting cessation treatment. Those barriers include:

- Copays, coinsurance and deductibles
- Requiring prior authorization of treatments
- Limits on how long a patient can use the treatment
- Limits on a patient's number of quit attempts per year
- Limits on a patient's number of quit attempts per lifetime
- Requiring stepped-care therapy[i]
- Requiring counseling for coverage of medications

2. Promote the benefit among members/employees

A model cessation benefit will only get results if members/employees/enrollees know it's available and how they can access it. Promoting cessation benefits and making these promotions easy to understand and audience-appropriate is vital to helping tobacco users quit.

3. Track results

Employers/plans should track how many smokers use tobacco cessation treatments and whether they quit as a result. These data can be used to determine successes of the benefit, and improve its promotion and design.

[i] Stepped care therapy is a policy that requires patients to try a particular treatment first before trying others.

Tobacco Cessation Coverage: What is Required?

The Patient Protection and Affordable Care Act (ACA) was passed in March 2010, and many of its major provisions have been implemented over the last four years, culminating in new insurance coverage available to many Americans starting January 1, 2014. How did the ACA change requirements for what plans should be covering to help smokers quit in 2014?

Insurance Type	Who?	Required coverage before ACA	Required coverage now
Medicare	Age 65+ or some disabled individuals	■ 4 sessions of individual counseling ■ 4 prescription cessation medications ■ Up to 2 quit attempts per year	■ 4 sessions of individual counseling ■ 4 prescription cessation medications ■ Up to 2 quit attempts per year ■ No cost-sharing ■ Annual prevention visit
Traditional Medicaid	Low-income or disabled individuals, eligibility varies by state	No federal requirements, coverage varied by state	**For Pregnant Women:** ■ Individual, group and phone counseling ■ All tobacco cessation medications (prescription and OTC) ■ No cost-sharing **For all Medicaid Enrollees:** ■ All tobacco cessation medications (prescription and OTC) ■ Coverage of counseling varies by state/plan ■ Cost-sharing varies by state/plan
Medicaid Expansion	Low-income or disabled individuals, up to 138 percent of federal poverty level in states that expand Medicaid	Not applicable—Medicaid expansion did not exist prior to ACA	■ Tobacco cessation treatment as a preventive service (see pg. 5) ■ No cost-sharing ■ At least 1 tobacco cessation medications
Individual Insurance Plans*	Individuals not buying insurance through an employer or part of a group, including through state health insurance marketplaces	No tobacco cessation requirements	■ Tobacco cessation treatment as a preventive service (see pg. 5) ■ No cost-sharing ■ 1-3 tobacco cessation medications, depending on the benchmark plan
Small Group Plans*	Individuals buying insurance through their small employer (100 or less full-time employees) or another small group, including through state health insurance marketplaces	No tobacco cessation requirements	■ Tobacco cessation treatment as a preventive service (see pg. 5) ■ No cost-sharing ■ 1-3 tobacco cessation medications, depending on the benchmark plan
Employer-Provided Plans (Large Group/ Self-Insured)*	Employees receiving insurance coverage through their employer	No tobacco cessation requirements	■ Tobacco cessation treatment as a preventive service (see pg. 5) ■ No cost-sharing

*Excluding plans that are "grandfathered" (those that were in operation before March 2010 and have not made significant changes) and do not have to meet ACA requirements.

Cost-sharing: money a patient must pay when receiving treatment/filling a prescription—copays, deductibles, coinsurance, etc.

OTC Medication: medication you can buy "over-the-counter" without a prescription

Benchmark plan: the plan each state has chosen to set the standard for other plans in the State Health Insurance Marketplace

Tobacco Cessation Treatment as a Preventive Service

The ACA requires many health insurance plans to cover all preventive services given an 'A' or 'B' rating by the U.S. Preventive Services Task Force (USPSTF). Tobacco cessation for adults has an 'A' rating from the USPSTF. However, the USPSTF rating and related recommendation was written for healthcare providers, not as a model for insurance coverage policy. As a result, there have been many questions since ACA implementation began in 2010 about what plans are required to cover for tobacco cessation. Evidence began to mount that most plans were not covering a true comprehensive cessation benefit.[13,14,15] The American Lung Association and other public health organizations repeatedly asked for clarification and guidance from the agencies implementing the ACA.[16]

On May 2, 2014, the Departments of Health and Human Services, Labor and Treasury provided guidance on this topic. The departments issued a FAQ document,[17] translating the USPSTF recommendation into insurance coverage policy. The guidance stated that the Departments would consider the relevant health plans to be in compliance with the preventive service requirement for tobacco cessation if they cover, for example:

- Screening for tobacco use
- Individual, group or phone counseling (at least 10 minutes per session)
- All FDA-approved tobacco cessation medications (prescription and over-the-counter) when prescribed by a healthcare provider
- At least two quit attempts per year
- 4 sessions of counseling and 90 days of medication per quit attempt
- No prior authorization is required for treatment
- No cost-sharing is required

Other Federal Actions to Help Smokers Quit

Cessation Coverage for Military Families

In 2013, TRICARE, the health insurance program for military personnel, their families and retirees, announced that all members would now have access to an evidence-based, comprehensive tobacco cessation benefit. This benefit includes all 3 forms of counseling and all 7 Food and Drug Administration (FDA)-approved medications. Currently, the smoking rate in the military is 24.0 percent.[18] Reducing tobacco use in the military will save lives, save money and increase military readiness.

TIPS FROM FORMER SMOKERS

Tips from Former Smokers Media Campaign

Annette, 57; diagnosed with lung cancer at age 52

Tips from Former Smokers is the CDC's first-ever paid national tobacco cessation media campaign. It features emotional, personal stories that illustrate the toll that smoking-related illnesses have on both smokers and their families. The campaign strives to build public awareness of the dangers of smoking and secondhand smoke and to encourage smokers to quit.

The first round of ads ran for 12 weeks beginning in the spring of 2012. Subsequent reports from CDC showed the media campaign:

- Increased calls to tobacco quitlines by 132 percent
- Drove over 500,000 additional visits to www.smokefree.gov
- Encouraged 1.6 million smokers to try to quit
- Reduced the number of smokers in the U.S. by 100,000

Subsequent rounds of the media campaign in 2013 and early 2014 had similar results, and another phase of the campaign was launched in July 2014.

Rose, 59; started smoking at 13, diagnosed with lung cancer at 58

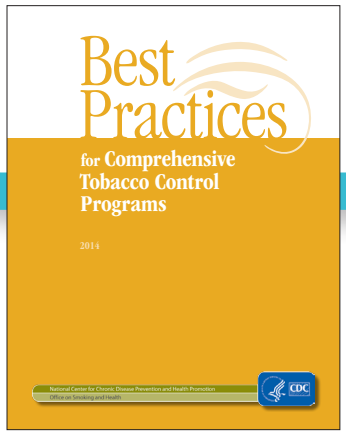
2014 Surgeon General's Report

On January 17, 2014, the U.S. Surgeon General released a report titled "The Health Consequences of Smoking—50 Years of Progress." As the title suggests, this report was released 50 years after the Surgeon General's first report on tobacco, which linked tobacco use to lung cancer in men. The 2014 report found lung cancer is the number one cancer killer of both women and men; and women are now just as likely as men to die from lung cancer or another smoking-related disease as men. In fact, smoking kills 480,000 Americans annually and smoking is responsible for 87 percent of all lung cancer deaths.[19]

The report shows encouraging progress. Over the past 50 years, the U.S. smoking rate has been cut from 42.7 percent to 18 percent, but there is still much more that can be done to help smokers[20] quit. As FDA asserts its power to regulate other tobacco products[21] and key provisions in the Affordable Care Act come into effect, there will be many additional resources to help smokers quit. The report says action must be taken to fulfill the "opportunity of the Affordable Care Act to provide access to barrier-free proven tobacco-use cessation treatment including counseling and medication to all smokers, especially those with significant mental and physical comorbidities."

Best Practices for Tobacco Control Programs

CDC's *Best Practices for Comprehensive Tobacco Control Programs* is the definitive evidence-based guide to help states develop robust, effective comprehensive tobacco control programs. The 2014 update to this document includes an expanded section on cessation interventions, recognizing the growing importance of state tobacco control programs working on cessation issues. The document encourages programs to "strive to increase both quit attempts and quit success by:



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

State Trends: Traditional Medicaid

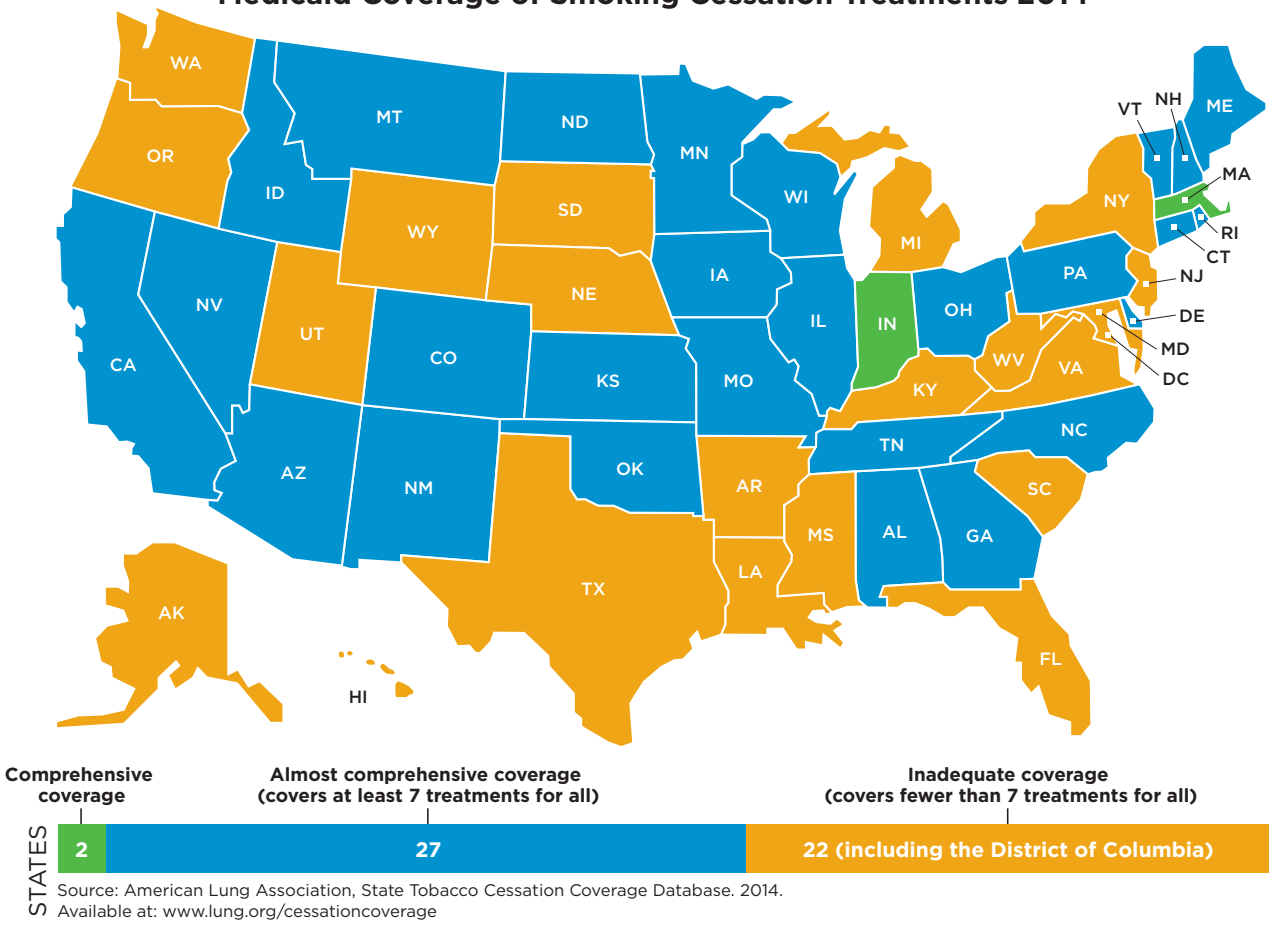
There is a tremendous need to help smokers on Medicaid quit. People enrolled in traditional Medicaid smoke at much higher rates than the general population (30.1 percent versus 18.1 percent for ages 18–65).[22]These Medicaid enrollees, by definition, have low incomes and are less able to pay out of pocket for tobacco cessation treatments. These are reasons enough to help people on Medicaid quit smoking, but there are more: smoking-related disease costs Medicaid programs millions of dollars every year—an average of $833 million per state in 2013.[23]

Two States Cover a *Comprehensive Tobacco Cessation Benefit for all Medicaid Enrollees:**

- Indiana
- Massachusetts

Despite these compelling reasons, most state Medicaid plans do not cover all treatments proven to help tobacco users quit. And beyond what is actually covered, ALL states have at least one policy in place that makes it harder for Medicaid enrollees to access covered treatments. The information below represents American Lung Association data as of June 30, 2014. For more details, see Appendices A and B.

Medicaid Coverage of Smoking Cessation Treatments 2014**



Source: American Lung Association, State Tobacco Cessation Coverage Database. 2014. Available at: www.lung.org/cessationcoverage

*Comprehensive coverage means coverage of all 7 FDA-approved medications for smoking cessation and individual, group and phone counseling. States are counted as covering phone counseling if they have an agreement with the state quitline or another quality phone counseling provider to pay for the costs of counseling for callers who are Medicaid enrollees.

**As of January 1, 2014 all Medicaid programs are prohibited from excluding coverage of tobacco cessation medications (section 2502 of the ACA). As of publication of this report, many states have not submitted State Plan Amendments reflecting this change. For the purposes of this report, states are not considered to be covering a medication unless there is documentable evidence that they are doing so.

State Trends: Traditional Medicaid

Too Many States Have Policies that make it Harder for Medicaid Enrollees to Access Treatment:

- **35 states charge copays**
- **36 states require prior authorization**
- **38 states limit duration of treatment**
- **37 states limit quit attempts per year**
- **6 states limit quit attempts per lifetime**
- **16 states have stepped care therapy**
- **23 states require counseling in order to obtain medications**

Under the ACA, most insurance plans for higher income individuals are not allowed to charge copays for preventive services. This prohibition does NOT apply to traditional Medicaid. This means many states are charging Americans with the lowest incomes for the help they need to quit smoking!

States Improving Medicaid Tobacco Cessation Coverage

Since the last edition of this report in 2012, several states have improved the cessation benefit offered to Medicaid enrollees or expanded the benefit to more people:

- The **Maine** legislature overrode a gubernatorial veto to pass legislation reinstating and expanding the state's tobacco cessation benefit, reversing cuts the governor made in 2011. The law was fully implemented in July 2014 and gives Maine one of the country's most comprehensive and easy to access Medicaid tobacco cessation benefits.
- **Alabama** and **Georgia** previously only covered tobacco cessation treatment for pregnant women, making these the only states in the U.S. to not provide at least some tobacco cessation help to all Medicaid enrollees. In 2014, both states began covering all cessation medications for all Medicaid enrollees. Georgia also extended coverage of individual counseling to everyone on Medicaid.
- **Connecticut**, **Ohio** and **Vermont** added coverage for one or more types of counseling for all Medicaid enrollees.

Managed Care Transitions

As containing costs and providing consistent care become more important goals for Medicaid agencies, more states are transitioning to or expanding their managed care systems. During these transitions, it is vital that provisions are in place for coverage of comprehensive tobacco cessation treatment. If not, decisions on coverage for quitting smoking are made by each individual plan. The resulting patchwork of coverage can be confusing to patients and healthcare providers, and the coverage offered by a particular plan is often less than comprehensive. Several states implemented these transitions since the last edition of this report:

- **Louisiana** transitioned from a fee-for-service system to managed care. While the previous tobacco cessation benefit was the same for all on Medicaid, now each managed care plan decides its own cessation benefit (including whether to offer a benefit at all).
- **Colorado**, **Kansas** and **New York** succeeded in standardizing tobacco cessation benefits among managed care plans, therefore ensuring quality benefits are available to all Medicaid enrollees and making the benefits easier to understand for tobacco users and healthcare providers.

State Trends: Medicaid Expansion

Individuals who are newly eligible for Medicaid in states that expanded the program as a result of the ACA are likely to have been previously uninsured.[24] This population smokes at a higher rate than the general population (in 2012 29.6 percent of uninsured smoked vs. 18.1 percent of the general population under 65).[25] These smokers also may not have been able to afford tobacco cessation treatment on their own because they lacked health insurance.

Enrolling in Medicaid is an opportunity for many individuals to finally access quality healthcare, and this should include comprehensive tobacco cessation treatment. The ACA recognized this by requiring that Alternative Benefit Plans (plans offered to Medicaid expansion enrollees) include coverage of preventive services (see pg. 5). These plans are also required to cover at least one FDA-approved tobacco cessation medication. States have several options when choosing plans to use with Medicaid expansion enrollees.

At the time of this report's publication, 26 states and the District of Columbia had implemented Medicaid expansion.[26] However, State Plan Amendments showing which plans are being offered to expansion enrollees were not available for all states. It is crucial that states and the Center for Medicare and Medicaid Services (CMS) make this information, as well as information on what benefits plans are covering for expansion enrollees, publicly available. This information is important for potential enrollees and healthcare providers who are treating these patients. It is also crucial for the public health and healthcare provider communities to be able to track this information to evaluate whether quality coverage is being offered to this population.

State Trends: State Health Insurance Marketplaces

The State Health Insurance Marketplaces, or "exchanges," are a hallmark of the Affordable Care Act, giving many Americans who were previously uninsured or lacked quality, affordable coverage the opportunity to get it. The ACA established the Essential Health Benefit (EHB), a minimum federal standard of healthcare benefits to ensure quality coverage is provided.

To implement this EHB in each state, the Department of Health and Human Services (HHS) instructed each state to choose a "benchmark" plan from a set of options. The coverage offered in this benchmark plan then becomes the minimum coverage standard for all individual and small group plans offered in the state (inside or outside of the official marketplace). These benchmarks will remain the standard in that state until at least 2016, when HHS is set to reevaluate this process.

Each benchmark plan, and therefore each small group and individual plan, is required to cover preventive services including tobacco cessation (see pg. 5). Plans are also required to cover one to three tobacco cessation medications: at least one medication, or as many as the benchmark plan covers (if more than one). These rules do not distinguish between the different types of nicotine-replacement-therapies, so any of the five FDA-approved therapies count as nicotine—making the maximum number of cessation medications counted here three instead of seven. While all nicotine replacement therapies (NRTs) contain nicotine, they use different mechanisms for delivering nicotine into the body, and these differences are significant when finding the right treatment for smokers. This seemingly minor detail can result in fewer tobacco cessation medications being required under coverage of plans in the state marketplaces—and in smokers not having access to all the medications that could help them quit. See Appendix C for information about each state.

As of this report's publication, the Lung Association was unable to obtain data on tobacco cessation coverage beyond the minimum number of medications required. Transparency is an important issue with State Health Insurance Marketplaces. Many plans being sold through the marketplaces consider detailed coverage information to be proprietary, and do not reveal it to non-members. One recent analysis found that detailed drug coverage information could only be obtained in one state.[27] This lack of transparency is troubling for consumers shopping for coverage and makes it difficult to ensure that legally required coverage is being provided. The American Lung Association encourages HHS and states to make more information about benchmarks and other plans available so a proper evaluation can be done of what coverage consumers are actually being offered.

State Trends: Tobacco Surcharges

The ACA prohibits many discriminatory practices by insurance companies, like exclusions of coverage for pre-existing conditions and charging women more in insurance premiums than men. However, the legislation singled out tobacco use as one of the only factors for which companies are allowed to vary premiums. Individual and small group plans are allowed under the law to charge tobacco users up to 50 percent more in premiums than nonsmokers. This surcharge can be a difference of thousands of dollars per year for a member.

States Limiting or Prohibiting Tobacco Surcharges:

- Arkansas
- California
- Connecticut*
- District of Columbia
- Kentucky
- Massachusetts
- New Jersey
- New York
- Rhode Island
- Vermont

*Rate differs between individual and small group markets.

There is no evidence that tobacco surcharges are effective in encouraging smokers to quit or reducing tobacco use. The American Lung Association is very concerned that increasing tobacco users' premiums will make insurance unaffordable for tobacco users and their families, forcing them to go uninsured with no access to the important cessation treatments and other medical treatment they need.

States are allowed to limit tobacco surcharges to amounts smaller than 50 percent for plans in the state or prohibit surcharges altogether. The box to the left lists states that have taken one of these actions as of June 30, 2014.[28]

If an insurance plan or employer does decide to include a tobacco surcharge, the American Lung Association strongly encourages them to:

- Offer a comprehensive tobacco cessation benefit to help tobacco users quit
- Allow tobacco users the opportunity to avoid the surcharge by enrolling in a tobacco cessation program (this is required for small group plans)
- Phase in the surcharge over a year or more so tobacco users have time to quit

State Trends: State Employee Health Benefits

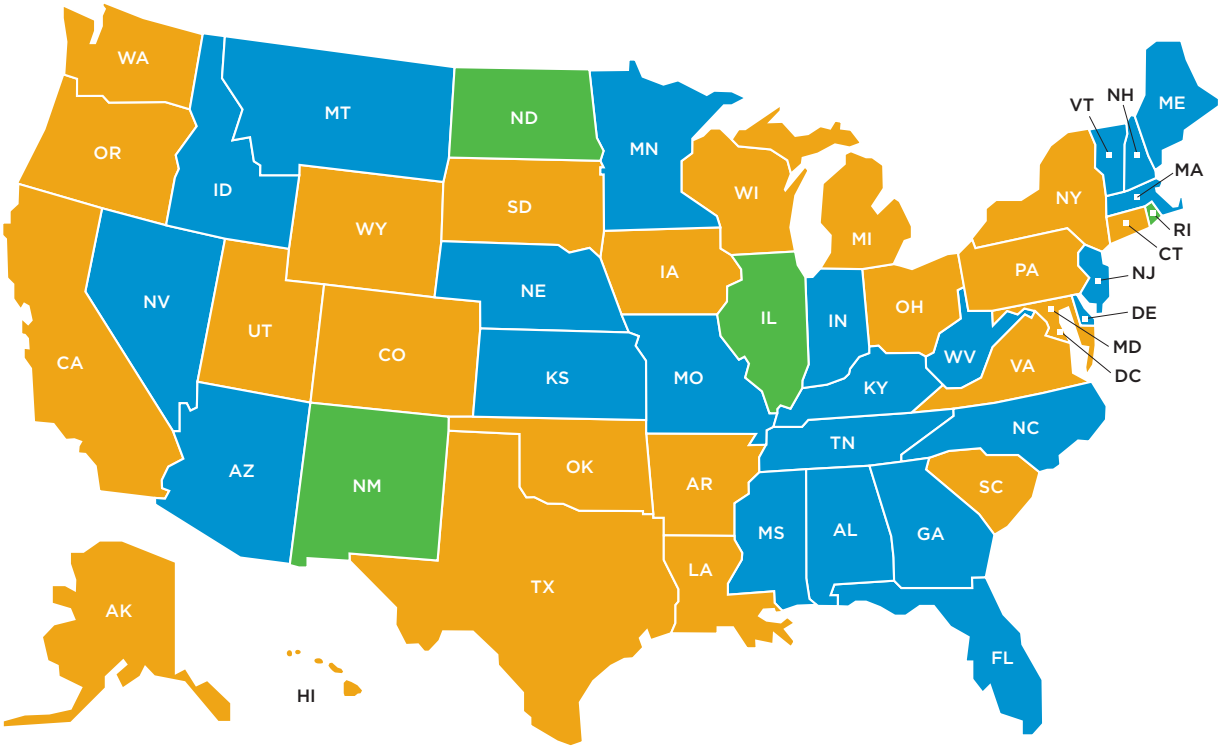
Every state provides health insurance to state employees.[29] As state government is often one of the largest employers in that state, what it decides to cover affects a large number of people. Many state employee plans also serve as examples or benchmarks for other health plans in the state. Therefore, it is important that these health plans lead by example and include a comprehensive cessation benefit for tobacco users—not only to create a healthier state workforce but also to help others in the state. Furthermore, helping state employees who smoke to quit will directly save state taxpayers money.[30]

Most states do not do enough to help state employees and their families quit smoking. The information below represents American Lung Association data as of June 30, 2014.

Four States Cover a Comprehensive Tobacco Cessation Benefit for All State Employees:

- Illinois
- New Mexico
- North Dakota
- Rhode Island

State Employee Health Plan Coverage of Smoking Cessation Treatments 2014



Source: American Lung Association, State Tobacco Cessation Coverage Database. 2014.
Available at: www.lung.org/cessationcoverage

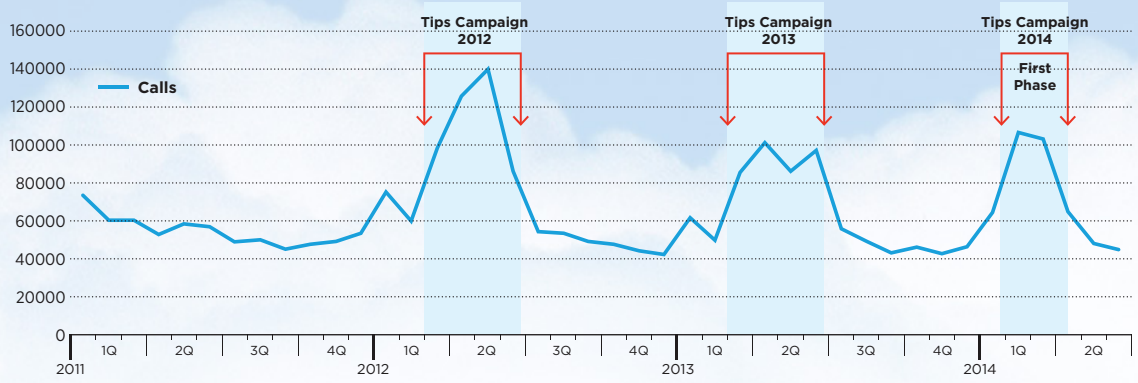
State Trends: Quitlines

Quitlines are an essential part of any state's tobacco cessation efforts. Quitlines provide phone counseling to tobacco users through a toll-free number, and assist doctors, friends and family of smokers who want information. All state quitlines can be reached by calling 1-800-QUIT-NOW, a national number that will route the caller to the appropriate state. Quitlines are especially important for smokers who live far away from their doctor or clinic, are uninsured or cannot afford paying for treatment. Quitlines can, and often do, serve as the first and sometimes only line of help for smokers who want to quit.

The value of quitlines is clearly apparent when the Tips from Former Smokers media campaign airs. The graph below shows how publicizing 1-800-QUIT-NOW through the Tips campaign has increased calls to quitlines.

Unfortunately, quitlines in this country are chronically underfunded. According to 2014 American Lung Association data, states and the federal government invested in quitlines, on average, $3.76 per smoker per state.[31]

Calls to Quitlines Increased Dramatically in Response to the "Tips" Campaign



Source: 1-800-Quit Now Call Attempts Data for U.S. States prepared by National Cancer Institute, available at: http://www.naquitline.org/.

Helping Smokers Quit: An Action Plan for Policymakers

Federal Government

- Extend the requirement for preventive services with no cost-sharing to traditional Medicaid plans and Medicare.
- Educate private health plans, employers and health insurance commissioners about the comprehensive tobacco cessation benefit outlined in ACA FAQ Part XIX (see pg. 5) and set up a system to track insurer's compliance with the guidance.
- Continue to promote and encourage tobacco cessation through media campaigns like the Tips from Former Smokers campaign, and continue to support state quitlines.
- Congress should support the Prevention and Public Health Fund and ensure it is only used for its original purpose of prevention, including recognizing the importance of evidence-based community quit smoking initiatives through CDC.
- Require all plans offered through State Health Insurance Marketplaces to publish detailed coverage information, including specific medications and preventive services covered.

State Governments

- Ensure that all group and individual health plans sold in the state cover a comprehensive tobacco cessation benefit such as the one outlined in ACA FAQ Part XIX (see pg. 5).
- Ensure that all Medicaid enrollees have access to a comprehensive tobacco cessation benefit, and remove barriers to accessing the benefit, especially co-pays.
- If necessary, submit a State Plan Amendment complying with Section 2502 of the ACA, establishing Medicaid coverage of all tobacco cessation medications. Ensure these medications are added to preferred drug lists/formularies and are easily available to Medicaid enrollees.
- Expand Medicaid to the federal eligibility minimum established in the ACA, and ensure that coverage offered to new enrollees includes a comprehensive tobacco cessation benefit.
- Fund state tobacco control programs, including quitlines, at the recommended level.

Health Plans/Employers/Health Systems

- Ensure that every patient is screened for tobacco use and, if the patient uses tobacco, offered cessation treatment.
- Provide all patients who use tobacco access to a comprehensive tobacco cessation benefit, removing as many barriers as possible.
- Publicize quit smoking benefits to patients, members and employees. Promotions should be tailored to the appropriate audience and make it clear how to get treatment.
- Track utilization of tobacco cessation benefits and patients' success in quitting.

American Lung Association Smoking Cessation Programs

The American Lung Association helps tens of thousands of smokers quit every year. More information about these programs can be found at www.lung.org/stop-smoking.

Freedom From Smoking®

Considered "America's gold standard in smoking cessation programs," Freedom From Smoking® has been helping smokers quit for over three decades. The program is offered as an in-person group clinic, an online program available at www.FFSonline.org and a self-help manual. Freedom From Smoking® builds smokers' motivation to quit, helps them create a personalized quit plan, discusses medications to help them quit, guides them through their Quit Day, and then covers relapse prevention techniques to help new ex-smokers transition to their healthy new lifestyle.

AMERICAN LUNG ASSOCIATION®
Freedom
FROM SMOKING®

Not-On-Tobacco® (N-O-T)

N-O-T
NOT ON TOBACCO
AMERICAN LUNG ASSOCIATION

Not On Tobacco® is aimed at youth ages 14–19 and is the most widely available teen smoking cessation program in the country. N-O-T is a voluntary (non-punitive) program that offers participants support, guidance, and instruction on understanding the reasons they started smoking, preparing to quit, and preventing relapse after they've quit.

Lung HelpLine (1-800-548-8252)

The Lung HelpLine is a valuable resource to anyone interested in lung health. Staffed by registered nurses, respiratory therapists and smoking cessation counselors, the Lung HelpLine can help callers quit smoking, and refer them to local programs and treatments. Counselors at the HelpLine also answer questions about radon, lung diseases, air quality and many other issues.

References

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Constrol and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
2. U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
3. Jha P, et al. 21st-Century Hazards of Smoking and Benefits of Cessation in the United States. New England Journal of Medicine. January 24, 2013;368(4):341–50.
4. Lightwood JM, Glantz SA. Short-Term Economic and Health Benefits of Smoking Cessation—Myocardial Infarction and Stroke. Circulation. August 19, 1997; 96(4):1089-96.
5. Solberg LI, Maciosek MV, Edwards NM. Tobacco Cessation Screening and Brief Counseling: Technical Report Prepared for the National Commission on Prevention Priorities, 2006. July 2006, 325(7356):128.
6. Penn State University. American Lung Association. "Tobacco Cessation: the Economic Benefits." 2010. Available at: www.lung.org/cessationbenefits.
7. Richard P, West K, Ku L. The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts. PLoS One. January 6, 2012, 7(1).
8. Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. A Clinical Practice Guideline. US Department of Health and Human Services. Public Health Service, 2008. Available at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html.
9. Centers for Disease Control and Prevention. Quitting Smoking Among Adults—United States, 2001-2010. Morbidity and Mortality Weekly Report. 2011; 60(44):1513-9.
10. Fiore MC, Bailey WC, Cohen SJ, et al. 2008
11. Fiore MC, Bailey WC, Cohen SJ, et al. 2008
12. Fiore MC, Bailey WC, Cohen SJ, et al. 2008
13. Georgetown University Health Policy Institute. Implementation of tobacco cessation coverage under the Affordable Care Act: Understanding how private health insurance policies cover tobacco cessation treatments. November 26, 2012. Available at: http://tfk.org/coveragereport/.
14. Centers for Disease Control and Prevention. Health Plan Implementation of U.S. Preventative Services Task Force A and B Recommendations—Colorado, 2010. Morbidity and Mortality Weekly Report. October 7, 2011; 60(39):1348-50.
15. Kolade, FM. Tennessee Health Plan Tobacco Cessation Coverage. Public Health Nursing Journal. January-February 2014;31:28-35.
16. Most recently, see letter sent February 19, 2014: http://www.lung.org/get-involved/advocate/advocacy-documents/letter-sebelius-tobacco-cessation-benefit-02192014.pdf
17. United Sates Department of Labor. FAQs about Affordable Care Act Implementation (Part XIX). May 2, 2014. Available at: http://www.dol.gov/ebsa/faqs/faq-aca19.html.
18. Department of Defense. 2011 DoD Survey of Health Related Behaviors Among Active Duty Military Personnel. Washington D.C.: Department of Defense, 2013.
19. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Constrol and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
20. Ibid.
21. American Lung Association. Long Awaited FDA Proposal to Regulate E-Cigarettes, Cigars and Other Tobacco Products is an Important Step Forward for Public Health. April 24, 2014. Available at: http://www.lung.org/press-room/press-releases/advocacy/FDA-ECig-Deeming-Reg-Statement.html.
22. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2012. Analysis by the American Lung Association, Research and Program Services Division.
23. Armour BS, Finkelstein EA, Fiebelkorn IC. State-level Medicaid expenditures attributable to smoking. Prev Chronic Dis 2009;6(3):A84. http://www.cdc.gov/pcd/issues/2009/jul/08_0153.htm. Accessed [May 19, 2014].Smoking-attributable Medicaid costs are updated from 2004 to 2013 dollars, using the Medical Consumer Price Index.
24. Kaiser Family Foundation. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Available at: http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ Accessed May 12, 2014.
25. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2012. Analysis by the American Lung Association, Research and Program Services Division.
26. Center for Budget and Policy Priorities. Health Reform's Medicaid Expansion: a Toolkit for State Advocates. Available at http://www.cbpp.org/cms/index.cfm?fa=view&id=3819. Accessed May 9, 2014.
27. Hirschler, Ben, and Ransdell Pierson. Reuters. Pfizer chases AstraZeneca for potential $100 billion deal. April 28, 2014. Available at: http://reut.rs/1kcn5Yp.
28. Centers for Medicare and Medicaid Services, Center for Consumer Information & Oversight. Market Rating Reforms. Available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html. Accessed May 9, 2014.
29. National Conference of State Legislatures. State Employee Health Benefits. New Material Added September 20,

2012. Available at: http://www.ncsl.org/IssuesResearch/Health/StateEmployeeHealthBenefits2009EditionNCSL/tabid/14345/Default.aspx.

30. Lightwood JM & Glantz SA, 1997; Solberg LI, Maciosek MV, Edwards NM., 2006.
31. American Lung Association. State of Tobacco Control 2014 Report. January 2014. Available at: http://www.stateoftobaccocontrol.org/.

Methodology

Data reported in this report was collected by staff of the American Lung Association (unless otherwise noted). These data were collected from July 2013–June 2014, and are intended to reflect coverage in effect as of June 30, 2014. Data were collected through extensive Internet and document searches, as well as through contact with relevant Medicaid, Department of Health and Quitline staff in the states. Sources for data on Medicaid coverage of cessation treatments include state Medicaid websites, Medicaid handbooks, provider policy manuals and regulations and legislation. Sources for data on Medicaid coverage of phone counseling include American Lung Association communications with quitline staff and the North American Quitline Consortium's case study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines. Sources for data on cessation coverage in state employee health plans include state employee benefits websites, summary health plan documents and provider policy manuals. Data on state quitlines were collected via survey of quitline and tobacco control program staff. For detailed information on coverage in each state and a specific state-by-state list of sources, please visit www. lung.org/cessationcoverage.

Appendix A:
Medicaid Coverage of Cessation Treatments

	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Inhaler	NRT Lozenge	Varenicline (Chantix)	Bupropion (Zyban)	Group Counseling	Individual Counseling	Phone Counseling
Alabama	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	P	Yes
Alaska	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	No
Arizona	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	P	Yes
Arkansas	Yes	Yes	No	No	No	Yes	Yes	No	Yes	Yes
California	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	*	*
Colorado	Yes	Yes	Yes	Yes	Yes	Yes	Yes	P	P	Yes
Connecticut	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Delaware	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
District of Columbia	*	*	No	No	*	No	No	No	Yes	No
Florida	*	*	*	*	*	*	*	*	*	*
Georgia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Hawaii	Yes	Yes	*	*	*	*	*	*	*	*
Idaho	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Illinois	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Indiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Kansas	Yes	Yes	Yes	Yes	Yes	Yes	Yes	P	P	*
Kentucky	*	Yes	*	*	*	*	*	*	*	*
Louisiana	Yes	Yes	*	*	*	*	Yes	*	No	Yes
Maine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	+	Yes	No
Maryland	*	Yes	*	*	*	*	Yes	*	*	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	Yes	Yes	*	*	*	Yes	Yes	*	Yes	Yes
Minnesota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Mississippi	Yes	Yes	*	*	Yes	Yes	Yes	*	*	*
Missouri	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Montana	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes
Nebraska	Yes	Yes	No	No	No	Yes	Yes	*	Yes	No
Nevada	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
New Hampshire	Yes	Yes	Yes	Yes	Yes	Yes	Yes	P	Yes	No
New Jersey	Yes	Yes	*	*	*	*	Yes	No	No	No
New Mexico	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	*	*
New York	Yes	Yes	*	*	*	Yes	Yes	Yes	Yes	No
North Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	@	@	No
Ohio	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*
Oklahoma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Oregon	*	Yes	*	*	*	Yes	Yes	*	Yes	Yes
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	Yes	No
South Carolina	*	Yes	*	*	*	*	*	*	*	*
South Dakota	P	P	No	No	P	Yes	Yes	No	P	No
Tennessee	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	*
Texas	Yes	Yes	No	No	No	Yes	Yes	*	*	Yes
Utah	*	*	*	*	*	Yes	Yes	P	P	No
Vermont	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Virginia	*	Yes	*	*	*	*	Yes	*	Yes	*
Washington	*	*	*	*	*	*	*	No	*	*
West Virginia	Yes	Yes	Yes	Yes	Yes	No	Yes	*	No	*
Wisconsin	Yes	Yes	Yes	Yes	No	Yes	Yes	*	Yes	No
Wyoming	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	No

P Coverage only for pregnant women

* Coverage varies by health plan

\+ Coverage to be implemented July 1, 2014

@Data pending

Appendix B
Barriers to Cessation Coverage in Medicaid Programs

	Limits on Duration	Lifetime Limit on Quit Attempts	Annual Limit on Quit Attempts	Prior Authorization Required	Copayments Required	Stepped Care Therapy	Counseling Required for Medications
Alabama	Yes	No	Yes	Yes	No	No	Yes
Alaska	Yes	No	Yes	No	Yes	No	No
Arizona	Yes	No	Yes	No	No	No	No
Arkansas	Yes	No	Yes	Yes	No	No	Yes
California	*	No	*	*	No	*	*
Colorado	Yes	No	Yes	Yes	*	No	*
Connecticut	Yes	No	Yes	Yes	No	No	No
Delaware	No	No	Yes	Yes	Yes	Yes	Yes
District of Columbia	*	No	No	No	No	No	No
Florida	*	*	*	*	*	*	*
Georgia	Yes	No	Yes	Yes	No	Yes	Yes
Hawaii	*	No	Yes	*	*	*	*
Idaho	No	No	Yes	Yes	No	No	Yes
Illinois	No	No	No	No	Yes	No	No
Indiana	Yes	No	Yes	No	Yes	Yes	Yes
Iowa	Yes	No	Yes	Yes	Yes	Yes	Yes
Kansas	Yes	No	Yes	No	No	No	No
Kentucky	*	No	*	*	No	No	*
Louisiana	*	No	No	No	Yes	No	*
Maine	No	No	No	Yes	No	Yes	No
Maryland	*	*	*	*	*	*	*
Massachusetts	No	No	Yes	Yes	Yes	No	No
Michigan	*	*	*	*	*	*	*
Minnesota	No	No	No	No	Yes	No	No
Mississippi	*	No	No	No	Yes	No	No
Missouri	Yes	Yes	No	Yes	No	No	No
Montana	Yes	No	Yes	Yes	Yes	Yes	No
Nebraska	Yes	No	Yes	Yes	Yes	No	Yes
Nevada	Yes	No	Yes	Yes	Yes	No	No
New Hampshire	No	No	Yes	No	Yes	No	No
New Jersey	*	*	*	*	*	No	No
New Mexico	*	No	*	*	No	No	No
New York	Yes	No	Yes	*	*	No	No
North Carolina	No	No	No	No	Yes	No	No
North Dakota	Yes	No	Yes	Yes	Yes	No	Yes
Ohio	No	No	No	*	*	*	No
Oklahoma	Yes	No	Yes	Yes+	Yes	No	Yes
Oregon	*	No	*	*	*	No	*
Pennsylvania	Yes	No	Yes	*	Yes	No	No
Rhode Island	Yes	No	Yes	Yes	No	Yes	Yes
South Carolina	Yes	No	*	*	*	*	*
South Dakota	No	No	No	No	Yes	No	No
Tennessee	Yes	No	No	Yes	No	No	No
Texas	No	No	No	No	Yes	No	No
Utah	No	No	No	Yes	Yes	No	No
Vermont	Yes	No	Yes	Yes	Yes	No	No
Virginia	*	No	*	*	*	*	No
Washington	*	*	*	*	No	No	*
West Virginia	Yes	No	Yes	Yes	Yes	Yes	Yes
Wisconsin	No	No	No	No	Yes	No	No
Wyoming	Yes	No	Yes	No	Yes	No	No

* Barrier varies by health plan
+Barrier will be removed July 1, 2014

Appendix C:
Tobacco Cessation Coverage in Essential Health Benefit Benchmark Plans

State	Benchmark Plan (Issuer Name; Plan Name)	# of Tobacco Cessation Medications Covered	Mentions of Tobacco Cessation in Other Parts of Plan Summary Document
Alabama	Blue Cross Blue Shield of Alabama; 320 Plan	3	
Alaska	Premera Blue Cross Blue Shield of Alaska; Heritage Select Envoy	3	
Arizona	State of Arizona Self Insured Plan, administered by United Healthcare; Arizona Benefits Options EPO Plan, administered by United Healthcare	3	Prescription and OTC cessation aids (no quantity limit)
Arkansas	HMO Partners; HMO Partners, Inc. Open Access POS, 13262AR001	2	
California	Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan Group HMO 30 ID 40513CA035	0	
Colorado	Kaiser Foundation Health Plan of Colorado; Ded HMO 1200D	0	Smoking cessation programs (no quantity limit)
Connecticut	Connecticare, Inc.; Connecticare HMO	3	
Delaware	Blue Cross Blue Shield of Delaware; Simply Blue EPO 100 500	3	
District of Columbia	Group Hospitalization and Medical Services, Inc.; Blue Preferred PPO Option 1	0	
Florida	Blue Cross and Blue Shield of Florida; BlueOptions 5462	0	
Georgia	BCBS Healthcare Plan of Georgia, Inc.; HMO Urgent Care 60 Copay	3	
Hawaii	Hawaii Medical Service Association; HMSA Preferred Provider Plan 2010	3	Smoking cessation drugs (generic, preferred, and non-preferred) and counseling services (no quantity limit)
Idaho	Blue Cross of Idaho Health Services Inc.; Preferred Blue	3	Smoking cessation counseling visits (no quantity limit)
Illinois	Blue Cross Blue Shield of Illinois; Blue Cross Blue Shield of Illinois Blue Advantage	3	
Indiana	Anthem Ins Companies Inc (Anthem BCBS); Blue 5 Blue Access PPM Medical Option 6 Rx Option G	0	
Iowa	Wellmark Inc.; Copayment Plus	3	
Kansas	Blue Cross Blue Shield of Kansas; Comprehensive Major Medical – Blue Choice GF 500 Deductible with Blue Rx Card	3	
Kentucky	Anthem Health Plans of KY (Anthem BCBS); Anthem PPO	0	
Louisiana	Blue Cross and Blue Shield of Louisiana; GroupCare PPO	1	Tobacco use screening (no quantity limit)
Maine	Anthem Health Plans of ME (Anthem BCBS) Blue Choice 20 with Rx 10 30 50 50	3	Smoking cessation services (no quantity limit)
Maryland	CareFirst BlueChoice, Inc.; Blue Choice HMO HAS Open Access	0	
Massachusetts	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.; HMO Blue 2000 Deductible	3	
Michigan	Priority Health; 100 Percent Hospital Services Plan	3	
Minnesota	HealthPartners, Inc.; 500 25 Open Access	3	
Mississippi	Blue Cross & Blue Shield of Mississippi; Blue Network	0	
Missouri	Healthy Alliance Life Co (Anthem BCBS); Blue 4 Blue Access Choice PPO Medical Option 4 Rx Option D	0	

Appendix C Continued:
Tobacco Cessation Coverage in Essential Health Benefit Benchmark Plans

State	Benchmark Plan (Issuer Name; Plan Name)	# of Tobacco Cessation Medications Covered	Mentions of Tobacco Cessation in Other Parts of Plan Summary Document
Montana	Blue Cross and Blue Shield of Montana; Blue Dimensions	1	
Nebraska	Blue Cross Blue Shield of Nebraska; Blue Pride	3	
Nevada	Health Plan of Nevada, Inc.; Health Plan of Nevada Point of Service Group 1C XV 500 HCR	0	
New Hampshire	Matthew Thornton Health Plan (Anthem BCBS); Matthew Thornton Blue Health Plan	0	
New Jersey	Horizon HMO; Horizon HMO Access HAS Compatible	3	
New Mexico	Lovelace Insurance Company; Lovelace Classic PPO	3	
New York	Oxford Health Insurance, Inc.; Oxford EPO	0	
North Carolina	Blue Cross and Blue Shield of NC; Blue Options	3	
North Dakota	Sanford Health Plan; Stanford Health Plan HMO	0	
Ohio	Community Insurance Company (Anthem BCBS); Blue 6 Blue Access PPO Medical Option D4 Rx Iotuib G	0	
Oklahoma	Blue Cross Blue Shield of Oklahoma; RYB05	0	
Oregon	PacificSource Health Plans; Preferred CoDeduct Value 3000 35 70	0	Tobacco use cessation services (quantity limit)
Pennsylvania	Aetna Health Inc. (a PA Corp.); PA POS Cost Sharing 34 1500 Ded	0	
Rhode Island	Blue Cross & Blue Shield of Rhode Island; Vantage Blue BCBSRI	3	Smoking cessation services (no quantity limit)
South Carolina	BlueCross BlueShield of South Carolina; Business Blue Complete	0	
South Dakota	Wellmark of South Dakota; Blue Select	3	
Tennessee	BlueCross BlueShield of Tennessee; BCBST PPO	0	Tobacco use counseling in a primary care setting (quantity limit)
Texas	Blue Cross Blue Shield of Texas; RS26	0	
Utah	Public Employee's Health Program; Utah Basic Plus	2	Tobacco use screening and tobacco use cessation interventions (specific drugs covered and quantity limit)
Vermont	The Vermont Health Plan, LLC; BlueCare, The Vermont Health Plan, LLC, CDHP	3	
Virginia	Anthem Health Plans of VA (Anthem BCBS); KeyCare 30 eith KC30 Rx Plan 10 30 50 or 20	0	
Washington	Regence BlueShield; Regence Blue Shield non-grandfathered small group product	3	
West Virginia	Highmark Blue Cross Blue Shield West Virginia; Super Blue Plus 2000 1000 Ded	3	
Wisconsin	UnitedHealthcare Insurance Company; Choice Plus Definity HSA Plan A92NS	0	
Wyoming	Blue Cross Blue Shield of Wyoming; Blue Choice Business 1000 80 20	3	

U.S. Department of Health and Human Services. Additional Information on Proposed State Essential Health Benefits Benchmark Plans. Baltimore, MD: U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, The Center for Consumer Information and Insurance Oversight. 2014. Available at: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html

Note: each of the five nicotine-replacement-therapies for smoking cessation are counted as nicotine in this list, not as distinct medications.

Note: if a benchmark plan covers 0 smoking cessation drugs, then plans in the State Health Insurance Marketplaces must cover at least 1.

Appendix D:
State Employee Health Plan Coverage of Cessation Treatments

	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Lozenge	NRT Inhaler	Varenicline (Chantix)	Bupropion (Zyban)	Group Counseling	Individual Counseling	Phone Counseling
Alabama	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Alaska	Yes	Yes	No	Yes	No	No	No	No	Yes	No
Arizona	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Arkansas	No	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes
California	No	Yes	Yes	No	Yes	Yes	Yes	*	*	*
Colorado	*	*	No	No	No	No	No	*	*	*
Connecticut	Yes	Yes	No	Yes	No	Yes	Yes	No	No	*
Delaware	*	*	Yes	*	Yes	Yes	Yes	Yes	Yes	Yes
District of Columbia	*	*	*	*	*	*	*	*	Yes	*
Florida	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	No	*
Georgia	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes
Hawaii	Yes	Yes	No	*	*	*	*	*	Yes	Yes
Idaho	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Illinois	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Indiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**	Yes	No
Iowa	Yes	Yes	*	Yes	*	*	*	No	No	No
Kansas	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes
Kentucky	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes
Louisiana	*	*	*	*	*	Yes	*	No	*	*
Maine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Maryland	No	No	No	No	No	Yes	Yes	No	Yes	Yes
Massachusetts	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	*	*	*	*	*	*	*	*	*	*
Minnesota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Mississippi	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Missouri	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes
Montana	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes
Nebraska	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Nevada	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	*	No
New Hampshire	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
New Jersey	Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	*	No
New Mexico	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
New York	*	*	*	*	*	*	Yes	*	*	*
North Carolina	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	No	No	No	Yes	Yes	No	No	Yes
Oklahoma	*	*	Yes	*	*	Yes	Yes	No	*	Yes
Oregon	Yes	Yes	No	No	No	Yes	Yes	No	No	Yes
Pennsylvania	Yes	Yes	No	No	No	No	No	No	No	Yes
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
South Carolina	Yes	Yes	No	Yes	No	Yes	Yes	No	No	Yes
South Dakota	No	No	No	No	No	Yes	Yes	No	No	Yes
Tennessee	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes
Texas	No	No	No	No	No	Yes	Yes	*	No	*
Utah	No	No	No	No	No	Yes	Yes	No	No	No
Vermont	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Virginia	Yes	Yes	No	No	Yes	Yes	Yes	*	No	Yes
Washington	Yes	Yes	*	*	*	*	Yes	*	*	*
West Virginia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Wisconsin	No	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No
Wyoming	No	Yes	No	No	No	Yes	Yes	No	No	No

* Coverage varies by health plan

** Coverage provided only under certain conditions

About the American Lung Association

Now in its second century, the American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease. With your generous support, the American Lung Association is "Fighting for Air" through research, education and advocacy. For more information about the American Lung Association, a holder of the Better Business Bureau Wise Giving Guide Seal, or to support the work it does, call 1-800-LUNGUSA (1-800-586-4872) or visit www.Lung.org.

AMERICAN LUNG ASSOCIATION®
Fighting for Air

July 2014