NORTH DAKOTA
Public Health Association

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Offer Comprehensive Medicaid Coverage for Tobacco Treatment

WHEREAS, "Tobacco product" means any product that is made from or derived from tobacco, or that contains nicotine or other similar substances, that is intended for human consumption or is likely to be consumed, whether smoked, heated, chewed, absorbed, dissolved, inhaled or ingested by any other means, including, but not limited to, a cigarette, a cigar, pipe tobacco, chewing tobacco, snuff or snus. Tobacco product also includes any electronic smoking device. This excludes any FDA-approved nicotine replacement therapy. This also excludes the sacred, medicinal and traditional use of tobacco by American Indians and other groups.

WHEREAS, despite longstanding declines in cigarette smoking prevalence, smoking is the leading preventable cause of morbidity and mortality in the United States[1]

WHEREAS, quitting smoking has immediate and long-term health benefits and yields healthcare cost savings[1]

WHEREAS, smokers who quit by age 40 reduce the excess risk of death associated with continued smoking by about 90%[1]

WHEREAS, smoking prevalence is twice as high in Medicaid recipients compared to privately-insured individuals[1]

WHEREAS, states with Medicaid policies permitting both counseling and pharmacotherapy had more quit attempts and successful quit attempts[2,3]

WHEREAS, the American Lung Association has rated North Dakota a "C", due to significant barriers to accessing care, for Medicaid recipients[4]

WHEREAS, smoking costs $325,798,988 in direct health care costs, to North Dakota[4]

WHEREAS, tobacco cessation and counseling will lead to substantial savings in Medicaid programs and reduced Medicaid claims[4]

WHEREAS, tobacco dependence treatment is one of the most cost-effective preventive services, providing substantial return on investment in the short and long term[5]

THEREFORE, be it resolved, the NDPHA supports that ND Medicaid cover comprehensive tobacco treatment to include individual and group counseling as well

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as medication, and remove barriers to accessing treatment such as copays, prior authorization, requirement of counseling for medications, limits on duration of treatment and limits on number of quit attempts.

References:

1.) DiGiulio A, Jump Z, Yu A, et al. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments — United States, 2015–2017. MMWR Morb Mortal Wkly Rep 2018;67:390–395. DOI: http://dx.doi.org/10.15585/mmwr.mm6713a3.
2.) Naavaal, Shillpa et al. Variations in Cigarette Smoking and Quit Attempts by Health Insurance Among US Adults in 41 States and 2 Jurisdictions, 2014. Public Health Reports Vol. XX(X) 1-9. DOI: 10.1177/0033354917753120
3.) Ku L, Brantley E, Bysshe T, Steinmetz E, Bruen BK. How Medicaid and Other Public Policies Affect Use of Tobacco Cessation Therapy, United States, 2010–2014. Prev Chronic Dis 2016;13:160234. DOI: http://dx.doi.org/10.5888/pcd13.160234.
4.) State of Tobacco Control: North Dakota Report Card. American Lung Association; 2017. http://www.lung.org/assets/documents/tobacco/state-of-tobacco-control.pdf. Accessed April 18, 2018.
5.) Fior M, Jaen C, Baker T, et al. Treating Tobacco Use and Dependence: 2008 Update Clinical Practice Guideline. Rockville, MD: Public Health Service; 2008.