Saving Money

The Massachusetts Tobacco Cessation Medicaid Benefit

A Policy Paper

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Action TO QUIT
Advancing Tobacco Control Policy

Acknowledgements

George Washington University

Leighton Ku, Ph.D., M.P.H.
Professor of Health Policy
Director, Center for Health Policy Research
The George Washington University
School of Public Health and Health Service
Washington, DC USA

Partnership for Prevention

David Zauche, Managing Senior Fellow and Senior Program Officer

E. Ripley Forbes, Director of Government Affairs

Partnership for Prevention is a nonprofit organization dedicated to preventing illness and injury and promoting health. Partnership's programs reach policymakers, a wide range of public health and healthcare professionals, businesses, and others who can emphasize prevention.

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Foreword

In the United States, about 70% of smokers want to quit and 50% make a quit attempt each year. Unfortunately, only a small percent are successful, due in part to the lack of easy access to tobacco dependence treatments that have been proven effective. In light of the societal costs of tobacco-related illness, government must do everything it can to encourage and enable smokers to quit.

The tobacco use landscape in this country has changed in recent years -- people with lower income and education levels have a much higher probability of smoking. For instance, the smoking rate for those with a college degree is under 10%, but for those insured by Medicaid it is over 35%. Unfortunately, Medicaid coverage for tobacco cessation treatment depends on the state in which you live. While federal health reform guarantees nationwide coverage for pregnant women, it does not for all other Medicaid beneficiaries. Some states have made this a public health priority, but others have not.

This policy report, based on a study by George Washington University, demonstrates that implementation of a comprehensive tobacco cessation program can saves lives and money. At a time when state and federal budgets are stretched to the breaking point, this report identifies a proven cost saving strategy for policy makers.

It is imperative that states redouble their efforts to establish comprehensive coverage for tobacco treatment for all people insured by Medicaid. Tobacco control advocacy organizations must fully support this campaign and include it in their 2012 plans of action. Giving all Americans unfettered access to cessation services will help millions of smokers quit, saving human life and financial expenditure.

Jud Richland, President

Partnership for Prevention

Executive Summary

A new research study from the George Washington University demonstrates that including a comprehensive smoking cessation benefit as part of insurance coverage under Medicaid can:

1. Help people stop smoking,
2. Lower the risk of heart-related illnesses that lead to hospitalization, and
3. Save money by reducing the number of costly hospitalizations.

The George Washington University research report concluded that every $1 invested in the Massachusetts Medicaid Tobacco Cessation Program led to average savings of $3.12 in cardiovascular -related hospitalization expenditures. Thus, a net return on investment of $2.12 was realized for every dollar invested. On average, these savings were recouped within slightly more than a year after the benefits were used.

Most states currently offer some coverage for tobacco cessation under Medicaid, but few offer a comprehensive benefit. Advocates in many states are actively working to increase Medicaid tobacco treatment coverage and the new study and this policy paper will be excellent new tools to strengthen their campaigns.

In summary, this new research shows that linking public health efforts to decrease smoking with insurance coverage for counseling and cessation medications can be an effective strategy to improve population health and lower health care costs.

The new George Washington University study is available at:
http://dx.plos.org/10.1371/journal.pone.0029665

Introduction

Smoking is the number one preventable cause of death and disease in the United States. About 440,000 people die from causes attributed to smoking each year. For each death, an additional 20 people suffer from a smoking-related disease, including heart attacks, coronary heart disease, lung cancer, emphysema and chronic obstructive pulmonary disease.[1] While about one out of every five Americans smokes, the rate among low-income adults insured by the Medicaid program is almost twice as high.[2] The costs of treating tobacco-related illnesses in Medicaid were estimated to be about 11 percent of the total program cost, or $22 billion, in 2004.[3] Today, 11 percent of total Medicaid costs would be twice as high, almost $50 billion per year.

Because of the stark toll of smoking and the prevalence of smoking among low-income Medicaid beneficiaries, strategies to reduce smoking among this population rank high on the public health agenda for the nation. One of the Healthy People 2020 public health objectives for the U.S. is to "increase comprehensive Medicaid insurance coverage of evidence-based treatment for nicotine dependency in States and the District of Columbia."[4] The new findings discussed in this report show that smoking cessation should not only be part of our public health objectives, but also a critical element of the national agenda to lower the costs of medical care.

After an extensive review of the research evidence, the U.S. Public Health Service has recommended using a variety of clinical treatment options, including counseling and medications, to promote smoking cessation:[5]

- Nicotine replacement therapy, including gum, patch, nasal spray, inhaler and lozenge
- Varenicline (Chantix)
- Bupropion (e.g., Zyban and generic equivalents)
- Group, individual, and telephone counseling

Comprehensive tobacco cessation coverage consists of all seven first-line medications and all three

recommended counseling strategies. This flexible coverage will permit smokers to choose the type of treatment that is appropriate for them. The recommendations note that medications and counseling are both effective themselves, but that combined use may be the most effective.

The National Commission on Prevention Priorities, convened by Partnership for Prevention, ranks clinical preventive services based on their health impact and cost effectiveness. It is noteworthy that the Commission assigned tobacco cessation treatment a place at the top of its list of clinical services in these two categories. The ranking of clinical preventive services is available at:

http://www.prevent.org/data/files/initiatives/prioritiesamongeffectiveclinicalpreventivesvcsresultsofreviewandanalysis.pdf

Medicaid and Tobacco Cessation

Medicaid is a joint federal-state program that provides health insurance coverage to low-income people in the United States, including children, adults, seniors and people with disabilities. About 57 million people will participate in Medicaid during an average month in 2012, making it the largest insurance program in the nation. The Patient Protection and Affordable Care Act (ACA) requires a large expansion of Medicaid eligibility for adults with incomes under 133 percent of the federal poverty line beginning in 2014. The Congressional Budget Office expects enrollment to exceed 70 million by later in the decade.[6]

Medicaid beneficiaries may receive smoking cessation medications and counseling, although the specific benefits and policies are determined by state Medicaid programs. Federal law (Title XIX of the Social Security Act) establishes the basic framework for this entitlement program, but places many of the key operational requirements and decisions in the hands of states. This includes many aspects of eligibility for Medicaid coverage, the health benefits that are covered, and how much to pay for health care services. The federal government pays for the majority of Medicaid costs, on a matching basis with states. The level of federal matching generally depends on the per capita income in states: states with lower incomes receive a higher federal matching rate than states with higher per capita incomes. Federal policy changed with the passage of the ACA in early 2010. Effective October 2010, all state Medicaid programs are required to offer comprehensive cessation benefits for pregnant women, including medications recognized as effective, diagnostic and counseling services. These services must be available without copayments.[7] Moreover, beginning in 2014, state Medicaid programs may no longer exclude tobacco cessation medications from coverage.[8]

Newly eligible adults (those with incomes up to 133 percent of poverty who are not eligible under current Medicaid rules) must at least receive “essential health benefits” established under the ACA for those covered by private health insurance. The ACA also requires coverage of all preventive services rated by the U.S. Preventive Services Task Force with an “A” or “B” recommendation without cost-sharing, and tobacco cessation services are included in that list. As noted earlier, it is expected that these expansions will increase the number of adults covered by Medicaid by more than 10 million.

For those already eligible for Medicaid, as indicated above, most states already cover at least some smoking cessation services. But the ACA offers higher federal matching rates to states that cover all Preventive Health Services Task Force-recommended services without cost-sharing.

The ACA has already led to expansions of smoking cessation coverage for pregnant women and further expansions of coverage will be required beginning in 2014. The Centers for Medicare & Medicaid Services (CMS) has encouraged states to adopt more comprehensive tobacco cessation policies consistent with those recommended by the U.S. Public Health Service. The CMS noted that federal matching funds are available to help states pay for the cessation services including medications, in-person counseling and telephone quitlines.[9] CMS also encouraged states to minimize barriers to use of these services by eliminating or minimizing copayments and to actively promote the availability of these services both to patients and providers.

New Research

Massachusetts' Comprehensive Tobacco Cessation Program

In July 2006, the state of Massachusetts initiated a comprehensive smoking cessation policy under its Medicaid program (called MassHealth). Based on prior research about effective smoking cessation interventions, the state passed legislation requiring a program that included both tobacco cessation medications, including all treatments that are approved by the Food and Drug Administration, as well as counseling services.[10]

Medicaid enrollees can obtain up to two 90-day regimens of smoking cessation medications per year, although higher levels could be permitted with preauthorization. The medications are available if prescribed by a Medicaid provider (doctor, nurse practitioner or physician assistant). Copayments are nominal ($1 to $3). Medications available include:

- Nicotine replacement therapy medications, including gum, patch or lozenge. With preauthorization, the nasal spray or inhaler can be authorized.
- Varenicline (Chantix) or bupropion (the generic form of Zyban).

Counseling is available, with up to 16 sessions per year, including two intake/assessment sessions and 14 counseling sessions (with more available with preauthorization), in the form of individual or group sessions. Since in-person counseling is not available statewide, participants can also use telephone counseling services, including Quitworks, a program offered by the Massachusetts Department of Public Health. These services are also available from all Medicaid managed care plans and some plans offer additional benefits.

Three studies of the Massachusetts program have been published. The first two were conducted by Dr. Thomas Land and his associates, primarily from the Massachusetts Department of Public Health. The third study was an independent cost-benefit study, conducted by researchers from George Washington University. (To provide the broad access to this research, all three studies were published in open-access journals that can be read and downloaded without charge.)

1. *Use of the program and the effect on smoking rates* (Land, et al. 2010a).[11] This study found that, in part because of broad publicity and outreach for the cessation program, the program achieved a high utilization rate, reaching about 37 percent of Medicaid smokers. Based on analyses of time trends from CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey, the rate of smoking among Medicaid beneficiaries fell from about 38 percent to about 28 percent in two and a half years, a statistically significant reduction. Available at http://www.plosone.org/article/info:doi%2F10.1371%2Fjournal.pone.0009770.

2. *The effect of the program on hospitalization rates for program participants* (Land, et al. 2010b).[12] This study investigated changes in inpatient hospitalization trends for those who used the cessation benefit, before and after they started using the tobacco medications. Based on an analysis of changes in hospitalization trends, the researchers found that admissions for heart attacks (acute myocardial infarction) fell by 46 percent and admissions for coronary heart disease fell by 49 percent. Admissions for non-specific chest pain fell by 32 percent, although these findings were marginally significant statistically. Admission rates for other causes, including respiratory disease, did not change significantly. Available at: http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000375

3. *The return on investment (the costs and benefits) of the program* (Richard, et al. 2012).[13] The George Washington University study, available at http://dx.plos.org/10.1371/journal.pone.0029665, measured the cost of the tobacco cessation program (medications, counseling and outreach) from administrative data and estimated the savings from reducing cardiovascular hospital admissions, based on analyses of the Medical Expenditure Panel Survey and the Behavioral Risk Factor Surveillance System, as well as the hospitalization study by Land, et al. All told, the study found the annual cost of the tobacco cessation benefit was $183 per user, but the averted annual hospital savings averaged $571 per participant (all in 2010 dollars). Every $1 invested in program costs led to average savings of $3.12 in cardiovascular-related hospitalization expenditures, so there was a net return on investment of $2.12 for every dollar invested. On average these savings were recouped within slightly more than a year after the benefits were used. These are conservative short-term estimates of savings, since they do not include longer-term savings, nor savings that

may occur outside the Medicaid program (e.g., increased worker productivity, reduced harm to other family members from second hand smoke, etc.). The table below summarizes the average annual cost of the program per participant and the average annual savings attributable to reductions in three types of cardiovascular disease. (The published article indicates a range of potential savings; this chart simply shows the average estimated costs and savings.)

Table 1. Summary of Average Costs and Inpatient Hospital Savings Attributable to Medicaid Smoking Cessation Program in Massachusetts					
(All in 2010 Dollars)	**Program Costs (Medications, Counseling, Outreach)**	**Savings from Fewer Heart Attacks**	**Savings from Less Coronary Heart Disease**	**Savings from Less Non-specific Chest Pain**	**Net Savings (Total Savings Minus Cost)**
Annual Cost per Cessation Benefit Par-	$183	$383	$117	$71	$388
Rate per Dollar Invested in Program	$1	$2.09	$0.64	$0.39	$2.12 = net return on investment

The combined lessons of these three studies are that:

- A comprehensive tobacco cessation program can reach a large proportion of Medicaid smokers and lead many of them – at least temporarily – to stop smoking.
- These smoking reductions can lead to lower rates of severe cardiovascular disease and lead to fewer hospital admissions for those causes.
- The program can be relatively inexpensive and can save much more than it costs; these savings can be quickly recouped by the Medicaid program.

Since Medicaid is jointly funded by both states and the federal government, there would be both state and federal savings. Currently, the federal Medicaid matching rate ranges from 50 percent for more affluent states to 74 percent for the state with the lowest per capita income, so states would retain about 26 to 50 percent of the savings.

Putting the Findings into Context

Years of research about smoking and efforts to quit reveal two important lessons. One, most smokers want to quit, but they often lack the tools to help them stop. Second, it is difficult to quit; most of those who quit relapse later. Tobacco dependence is a chronic disease and it may be necessary to help smokers to quit many times. Effective clinical treatments – using medications and/or counseling – are available.[5] The research also reveals that even relatively brief reductions in smoking can have important health paybacks such as reduced hospitalizations.

The Massachusetts studies do not reveal how many of the low-income smokers who quit remained tobacco-free or for how long. It is likely that many of those who quit, conceivably even most, eventually begin smoking again. Nonetheless, the annual medical savings attributable to even a brief reduction in smoking ($571 per program participant) outweighed the costs of the prevention program ($183 per participant) and yielded these savings rapidly. Moreover, those who started smoking again later could use the smoking cessation benefits again at a later time; the program administrators realized how hard it is to quit permanently and that repeated efforts may be needed.

The cost-benefit study provides conservative short-term estimates of the savings to the Medicaid program. They do not include other potential savings, such as the reduced cost of purchasing cigarettes (typically more than $5 per pack), health improvements in other family members due to reduced second-hand smoke, or improved work productivity or quality of life.

To some it may seem surprising that the savings due to smoking are related to heart health. Smoking leads to coronary heart disease and heart attacks, the leading cause of death in the United States. Tobacco use raises the risk of coronary heart disease by two- to four-fold and may particularly increase the risk of heart problems for non-elderly adults.[14] It raises blood pressure, reduces cardiac capacity and can harm blood vessels. Other analyses have found that smoking cessation can be the most cost-effective long-term method of reducing cardiovascular disease in the United States.[15]

It is worth noting that the study by Land, et al. did not investigate the potential effects of the smoking cessation program on improving birth outcomes among pregnant women. The study examined

hospital claims related to the program participants themselves and did not link records between pregnant women and their babies. While there is a substantial body of research about the harmful effects of smoking by pregnant women and about smoking cessation during pregnancy[16], this study was not designed to examine that issue.

It should also be noted that insurance coverage alone may not guarantee utilization of cessation treatments or decrease of smoking prevalence. Other factors come into play, most importantly aggressive promotion of the benefit and the available treatment services to both members and providers alike. Massachusetts implemented public awareness campaigns to inform Medicaid beneficiaries about the covered services, urging them to use the benefit to quit smoking. And repetitive promotion to providers by MassHealth, the Massachusetts Tobacco Control Program, and many partner organizations also helped ensure the success of the program.

States Can Expand Cessation Coverage Now

Until recently, federal policy encouraged, but did not require, state Medicaid programs to cover smoking cessation, including medications or counseling services. As of November 2011, most states offered at least some smoking cessation services under Medicaid.[17] Six states (Indiana, Massachusetts, Minnesota, Nevada, North Carolina and Pennsylvania) covered all the treatments recommended by the U.S. Public Health Service, including all five forms of nicotine replacement therapy (NRT), varenicline and bupropion as well as individual and group counseling. (NRT gum, patch and lozenge options are generally available on an over-the-counter basis, whereas NRT inhalers and sprays and varenicline and bupropion must be prescribed by a physician or approved clinician. However, in order for Medicaid to cover the costs of the over-the-counter NRT treatments, they must generally be prescribed by a physician or other approved clinician.)

Most of the rest of the states offered at least some of these services, although sometimes the benefits varied across Medicaid managed care plans or for different populations (e.g., pregnant women). The Appendix summarizes data about the level of smoking among low-income adults in each state in 2009-10 and the Medicaid smoking cessation coverage available as of November 2011. While all states could gain by reducing the level of smoking, the greatest gains can be realized in states with the highest smoking prevalence rates. It is particularly noteworthy that some of the states with the highest rates of smoking have less coverage; these include Georgia, Kentucky, Tennessee and West Virginia.

States do not need to wait to further expand Medicaid smoking cessation coverage options – they may adopt them at any time. However, a major barrier now facing many state Medicaid programs is state budget shortfalls. Most states are still recovering from the worst recession in recent decades, which led almost all states to take steps to contain Medicaid costs, such as reducing payment rates to providers or restricting the scope of benefits.[18] Budget concerns can make states reluctant to expand the scope of Medicaid benefits, no matter how worthy.

The budgetary significance of the findings from the Massachusetts studies is that comprehensive tobacco cessation programs can begin to recoup savings rapidly since hospitalization rates fall quickly.

The latest study indicates that most of the estimated savings may be recovered within a little more than a year. When budgets are tight, policy officials care most about policies that will save money in the following year or two. The Massachusetts results meet that test. Creating comprehensive tobacco cessation coverage policies in Medicaid can both improve public health and lower medical costs.

Because the prevalence of smoking is so high among the low-income Medicaid population, state officials should take steps to make comprehensive smoking cessation benefits available. This should include the full array of Food and Drug Administration approved medications and the counseling therapies recommended by the U.S. Public Health Service. The findings from the studies suggest that greater use of smoking cessation benefits leads to larger reductions in smoking rates, which in turn leads to lower rates of heart disease and to greater medical savings.

Planning for Better Health

Improving smoking cessation efforts in Medicaid involves at least two, and preferably three, phases.

Planning. The first step includes motivating the Medicaid agency or state legislature to expand smoking cessation coverage. Soon after, decisions must be made about what services or treatments to cover and how they will be delivered. The key governmental agencies to involve are the state Medicaid agency and the state public health agency; they are often separate agencies. Non-governmental organizations and individuals that can contribute to the planning may include:

- state affiliates of organizations like the American Heart Association, American Lung Association, American Cancer Society, or the American Public Health Association;
- health care organizations, such as state medical or nursing associations, community health centers, or hospitals;
- Medicaid managed care organizations;
- community organizations, including civil rights, health, religious or low-income advocacy organizations who want to promote public health; and
- respected public health experts.

Many organizations have created a variety of useful guidelines and recommendations in this area. Some resources include:

- U.S. Public Health Service. Treating Tobacco Use and Dependence: 2008 Update. http://www.ahrq.gov/clinic/tobacco/tobaqrg.pdf
- American Lung Association. Helping Smokers Quit. Tobacco Cessation Coverage 2011. http://www.lungusa.org/assets/documents/publications/smoking-cessation/helping-smokers-quit-2011.pdf.
- American Lung Association and Partnership for Prevention. Save Lives and Money. Help People on Medicaid Quit Tobacco. 2010. http://actiontoquit.org/uploads/documents/Save_Lives_and_Money_Medicaid_2010.pdf

- Partnership for Prevention. Increasing Access to Tobacco Cessation in States: Action to Quit Case. Studies. May 2011. http://actiontoquit.org/uploads/documents/A2QCase%20StudiesGuide_FINAL_6-2-11.pdf
- Partnership for Prevention. Colorado Tobacco Cessation and Sustainability Partnership, a Case Study. May 2011. http://actiontoquit.org/uploads/documents/Colorado%20Tobacco%20Cessation%20and%20Sustainability%20Partnership%20Case%20Study%205-6-11.pdf

Implementation. The continued involvement of organizations during the implementation phase is ultimately critical. Efforts to bolster smoking cessation will not work if smokers and their families and the health care provider community are not aware of the smoking cessation benefits available and how to use them. Insurance coverage alone will not guarantee utilization of tobacco cessation services – there must be accompanying communication efforts to promote them. The Medicaid and public health agencies can work together to develop educational materials and outreach plans that are appropriate for:

- Medicaid enrollees and their families;
- Clinicians who must prescribe the services, particularly community health centers and primary care physicians, nurse practitioners and physician assistants;
- Pharmacists and counselors who must provide the medications and counseling; and
- Managed care plans and pharmacy benefit administrators that will often administer the benefits.

Many of the materials that were developed in Massachusetts can be found at: http://quitworks.makesmokinghistory.org/tools-resources/masshealth.html.

Evaluation. Evaluation of the new coverage initiatives can help indicate whether they were successful and identify barriers that may have kept them from being as effective as they might have been. The studies reviewed in this analysis reveal the results from one state, but others may want to conduct evaluations of other states' initiatives. State public health departments,

universities or other research organizations may be able to help conduct evaluation analyses. Some of the critical questions are:

- Are Medicaid enrollees (or their families) and primary care clinicians aware of their tobacco cessation coverage? Do they understand how to use the benefits?
- How many Medicaid beneficiaries use the smoking cessation benefits and which kinds of benefits did they use? What types of people use the benefits? For example, how many are pregnant women, what are their ages and educational levels, and are they clustered in certain geographic areas?
- Are there changes in the rate of smoking among Medicaid beneficiaries or among those who use the benefits? How long do people remain tobacco-free?
- Are there changes in the use of medical services, such as hospitalization rates, emergency department use? Is there evidence of other health changes, such as better birth outcomes?
- What are the costs of the program and the savings attributable to it?

In an era in which policymakers are seeking proven interventions to improve heath and reduce spending, the Massachusetts Medicaid experience is both instructive and inspirational.

Appendix

Table 2. State Data about Smoking Prevalence and Medicaid Smoking Cessation Options

	Smoking Prevalence	Medicaid Smoking Cessation Options Available, Nov. 2011						Smoking Prevalence	Medicaid Smoking Cessation Options Available, Nov. 2011				
	% of Low-Income Adult Popn That Smokes, 2009-10	At Least 3 NRT Options	Varenicline (Chantix)	Bupropion (e.g., Zyban)	Group Counseling	Individual Counseling		% of Low-Income Adult Popn That Smokes, 2009-10	At Least 3 NRT Options	Varenicline (Chantix)	Bupropion (e.g., Zyban)	Group Counseling	Individual Counseling
Alabama	36	P	P	P	P	P	**Montana**	45	yes	yes	yes	no	yes
Alaska	40	yes	yes	yes	no	yes	**Nebraska**	41	no	yes	yes	no	yes
Arizona	26	yes	yes	yes	no	no	**Nevada**	36	yes	yes	yes	**	**
Arkansas	44	no	yes	yes	yes	yes	**New Hampshire**	44	yes	yes	yes	**	**
California	17	*	*	yes	*	*	**New Jersey**	28	*	*	yes	*	no
Colorado	29	*	yes	yes	*	*	**New Mexico**	35	*	*	*	*	no
Connecticut	33	+	+	+	+	+	**New York**	29	yes	yes	yes	yes	yes
Delaware	36	yes	yes	Yes	no	yes	**North Carolina**	38	yes	yes	yes	yes	yes
Dist. Columbia	42	*	*	*	*	*	**North Dakota**	41	yes	yes	yes	no	no
Florida	38	*	*	*	*	yes	**Ohio**	47	yes	yes	yes	no	yes
Georgia	41	P	P	P	no	P	**Oklahoma**	49	yes	yes	yes	no	yes
Hawaii	28	yes	yes	yes	*	*	**Oregon**	40	*	yes	yes	*	yes
Idaho	33	yes	yes	yes	no	no	**Pennsylvania**	41	yes	yes	yes	yes	yes
Illinois	30	yes	yes	yes	yes	yes	**Rhode Island**	32	yes	yes	yes	*	*
Indiana	46	yes	yes	yes	yes	yes	**South Carolina**	40	*	*	*	no	no
Iowa	37	yes	yes	yes	no	yes	**South Dakota**	43	no	yes	yes	no	no
Kansas	41	*	*	*	*	no	**Tennessee**	43	+	+	+	+	+
Kentucky	49	?	?	?	?	?	**Texas**	27	no	yes	yes	no	no
Louisiana	35	yes	yes	yes	no	no	**Utah**	21	**	yes	yes	P	P
Maine	43	yes	yes	yes	no	yes	**Vermont**	35	yes	yes	yes	P	P
Maryland	33	*	*	*	*	*	**Virginia**	44	*	*	*	*	*
Massachusetts	35	yes	yes	yes	yes	yes	**Washington**	34	*	*	*	*	*
Michigan	37	*	*	yes	*	yes	**West Virginia**	51	**	no	**	*	no
Minnesota	40	yes	yes	yes	yes	yes	**Wisconsin**	43	yes	yes	yes	*	yes
Mississippi	36	Yes	yes	yes	P	P	**Wyoming**	38	yes	yes	yes	no	yes
Missouri	45	yes	yes	yes	P	P	**United States**	**31**					

Notes:
- NRT Nicotine Replacement Therapy (gum, patch, lozenge, inhaler or nasal spray)
- * covered by some Medicaid health plans
- ** covered under some circumstances
- + new plan announced, but details not clear
- P pregnant women only
- ? data not reported

Sources: Smoking prevalence: Author's tabulation of 2009-10 Behavioral Risk Factor Surveillance System (Low-income means income below $25,000/yr. Smokers are current smokers.)
Medicaid coverage options: American Lung Association, Helping Smokers Quit: Tobacco Cessation Coverage 2011, Appendix B, Dec. 2011

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Partnership for Prevention

1015 18th Street NW

Suite 300

Washington, DC 20036

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