Helping Benefit Oregon Smokers
Case Study
Final Report
February 6, 2013

Wendy Bjornson, MPH
HBOS Project Director
Oregon Health & Science University
Smoking Cessation Center

INTRODUCTION

An important strategy for reducing tobacco use is to ensure that cessation services are covered and offered as part of routine health care. Health insurance coverage for tobacco cessation has been improving; more health insurers include cessation services as a covered benefit and new federal policies through the Affordable Care Act require health insurers to include tobacco cessation as part of covered preventive services.

The trends that are *increasing* coverage for tobacco cessation services also present an opportunity for *improving* the quality of tobacco cessation services. When the quality of these new benefits improves, they will be better able to fulfill their potential for reducing tobacco use. For quality improvement to occur, tobacco cessation benefits need to be aligned with evidence-based best practices that have been shown to yield results.

Health plans can vary substantially in the design and delivery of tobacco cessation benefits. Even when appearing to be well designed, added requirements and limitations may actually hinder their use. In some cases these requirements and limitations are shaped by health plan policies and practices that govern all offered benefits. But in some cases, these requirements and limitations are applied because information and expertise are not available to guide decisions.

These were the issues in 2010 as Oregon began implementing a new mandate to cover tobacco cessation services.

MANDATE BACKGROUND

In 2009, the Oregon Legislature passed Senate Bill 734 requiring all Oregon based health plans to cover a minimum of $500 for tobacco cessation services for members 15 years or older. The bill was intended to create a common floor of benefit coverage sufficient to pay for one to two courses of treatment. The intention also was to bring services available for commercially covered Oregonians more in line with services covered through Medicaid and Medicare and offered (funding permitting) through the Oregon Tobacco Quitline. With the passage of SB734, an estimated 70 percent of Oregonians had coverage for tobacco cessation services.

The immediate effect of the legislation was striking. In a pre-implementation survey conducted in late 2009 by the Oregon Coalition of Health Care Purchasers (OCHCP), only three health plans had tobacco cessation as a core benefit while two health plans only offered tobacco cessation as part of “enhanced benefits” to large employers. One plan offered no benefits and two plans offered tobacco cessation as a value-added benefit. One plan offered $150 reimbursement for classes but no coverage for medication and one offered the benefit as a “rider” that was purchased by only 12 percent of clients. In short, the benefits for Oregon commercial health plan members had large gaps in coverage.

After the implementation of SB734, all these health plans offered tobacco cessation services as a core benefit, but with many requirements limiting use including variations in cost sharing, program enrollment to gain access to medications, and variations in the quality of the benefit for larger

employers. Two plans changed their formulary to add medications. An unfortunate and unintended consequence of the legislation was that five of the health plans capped their tobacco cessation benefits at $500 per lifetime. Of these health plans, two had previously had an unlimited benefit.

Results of SB734	
Before	After
• Three plans had tobacco cessation as core benefit. • Two plans offered "enhanced benefits" to large employers (two clients). • One plan offered no benefit; two had value-added benefits. • One plan offered $150 for classes, no medication. • One plans offered a benefit as a "rider" – purchased by 12 percent of clients.	• Five plans added tobacco cessation as a core benefit (total = all eight survey respondents) some with limitations (co-pays, enrollment requirements, variations for larger employers). • Two plans changed their formulary to add medications. • Five plans capped benefit at $500/lifetime. (Two of these plans reduced previous unlimited benefit to $500 lifetime cap.)

At the same time, population data on the smoking and quitting prevalence rates in Oregon showed that there was significant room for improvement. Despite the 70% coverage rate by 2010:

- Less than 50 percent of Oregon smokers had tried to quit, stopping for one day or longer.
- Of those, about 45 percent tried over-the-counter nicotine replacement.
- About 25 percent tried a prescription medication.
- Only 11 percent got help from a program.

The juxtaposition of the new insurance mandate for tobacco cessation, the unintended outcomes of the legislation limiting access, and the clear need to improve benefit use to assist more tobacco users to quit prompted the OHA Tobacco Prevention and Education Program to take advantage of the opportunity to initiate a new program bringing health plans together to improve the quality and access to the newly mandated benefits.

HELPING BENEFIT OREGON SMOKERS (HBOS)

The HBOS project began in 2010 with a mission to improve the quality of the benefit offered by the Oregon based health plans. The underlying philosophy was that by improving the benefit, health plans could improve outcomes.

In many cases, both before and after SB734, the design of the tobacco cessation benefit was creating barriers for health plan members trying to quit. The barriers ranged from high cost sharing to requirements to submit a letter that documented enrollment in a program before accessing pharmacy benefits. The wide variation in benefits across health plans confused health care providers, who see patients from multiple health plans, and try to make referrals but do not know what is covered by their patient's insurance plan. And, by capping benefits or imposing strict limits on coverage, tobacco users

who would benefit from longer and more flexible treatment to be successful were unable to get what they needed.

To help address the unevenness and quality of benefit coverage, the HBOS project proposed three main goals:

1. To bring together representatives from health plans, health care organizations and agencies, employers and purchasers, brokers, and advocates to develop a consensus on a set of common benefit design recommendations.
2. To ask participating health plans and health organizations to officially endorse and adopt these recommendations.
3. To implement a communications strategy designed to reach the larger health community to promote adoption of the Recommendations for use in all Oregon based tobacco cessation benefits.

Collaborative Organization

The HBOS collaborative began with four founding members: Oregon Health & Science University, Oregon Public Health Division, Oregon Coalition of Heath Care Purchasers, and the American Lung Association of the Mountain Pacific Region. Invitation letters from these founding organizations were sent to the medical directors of all the Oregon based health plans and to other Oregon health agencies. During the course of the HBOS collaborative, two Medicaid health plans were also invited. The following is a list of all participating organizations:

HBOS Participating Organizations	
Health Plan	Organizations (*Founders)
• **Aetna®,** Seattle, WA. • **Kaiser Permanente®** Portland, OR. • **LifeWise Health Plan of Oregon,** Portland, OR. • **The ODS Companies,** Portland, OR. • **Providence Health Plans,** Portland, OR. • **Regence BlueCross Blue Shield of Oregon,** Portland, OR. • **CIGNA® HealthCare,** Seattle, WA. • P**acificSource Health Plans,** Springfield, OR. • **CareOregon**; Portland OR. (Medicaid plan) • **Family Care**; Portland, OR. (Medicaid plan)	• **American Cancer Society Action Network;** Portland, OR. • **American Lung Association® of the Mountain Pacific**, Tigard, OR**.*** • **American Heart Association**, Portland, OR. • **Oregon Coalition of Health Care Purchasers,** Portland, OR.* • **Oregon Public Health Division** Portland, OR. * • **Oregon Division of Medical Assistance Programs;** Portland, OR. • **Oregon Health & Science University**; Portland, OR.* (Program Coordination) • **Tobacco-Free Coalition of Oregon, Inc.,** Portland, OR. • **USI Northwest;** Portland, OR.

Collaborative Meetings

The HBOS Collaborative met for the first time in May 2010 and began a regular meeting schedule until December 2012. The meetings initially featured presentations on the tobacco dependence treatment and economic evidence base and discussions about health plan issues and perspectives on these benefits. As Collaborative members became more familiar with the background information, the meeting agendas turned to consider drafts of possible benefit design recommendations.

An initial decision by the Collaborative was not to recommend one common benefit but rather to achieve consensus on a common set of benefit design recommendations. This distinction was made in order to be as inclusive as possible, since each health plan was governed by its own policies and procedures. By providing recommendations that had flexibility, more health plans could find a path to adoption and endorsement.

The meetings continued through 2010 with discussions and proposals, finally arriving at a consensus on a set of 10 Benefit Design Recommendations in November 2010. These Recommendations are summarized below. A complete version, together with the resources and citations used as the basis for the Recommendations, can be found at www.smokefreeoregon.com/policy/helping-benefit-oregon-smokers.

Benefit Design Recommendations

The 10 benefit design recommendations are grouped in four general categories:

Outreach:

- Screen for tobacco use at every clinic visit for patients 15 or older and refer for treatment.
- Identify smokers through health risk appraisals and claims data and prompt program registration through direct outreach and promotions in member communications.

Evidence Based Treatment:

- Effective treatment is evidence-based and flexible.
- Have several options available alone or in combination.
- Counseling – individual, group, quit line, online services.
- Medications – prescription and non-prescription.
- Offer programs and medication benefits separately.
- Cover at least two quit attempts annually (e.g.: two program/counseling enrollments; 20-24 weeks of medications).

Limit Barriers

- Limit cost sharing to same as routine medical services or waive.
- Eliminate prior authorization to access medications.
- Eliminate program enrollment and other requirements to access medications.

Quality Assurance

- Track quit rates for enrolled members/employees.
- Measure provider performance and member participation rates.

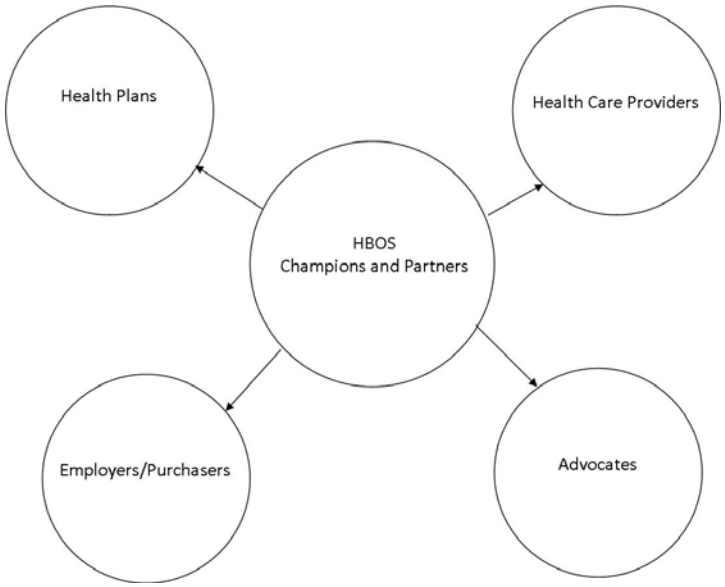
Endorsements

The next step for the Collaborative was to request endorsements from all participating members. The purpose of the endorsements was two-fold. First, by gaining official endorsements from the participating health plans and organizations, the Collaborative hoped to build momentum for a larger outreach effort. Second, since endorsements require an official signature, the executives in each of the health plans needed to review the Recommendations and compare them to the benefits offered by their health plan. This internal review process turned out to be lengthy and productive. Reports during the Collaborative meetings revealed that internal discussions were creating an opportunity to look more closely at their benefits and consider making changes. Since this was the intention behind developing the Recommendations, the endorsement process became an important strategy in reaching the internal decision process of the health plans.

Communication Strategy

Once the endorsements were completed, the publication of the Recommendations was officially announced with a press release and outreach to the business and health care media. Our target audiences were Oregon based health plans, employers, large benefit purchasers, and brokers. Our message promoted adoption of the Recommendations as a way to "magnify the positive outcomes of SB734." The Recommendations were promoted as being developed "in Oregon for Oregon" and that the "benefit of the benefit" was creating a standard of care that ensured better, easier access for help to quit, improving heath and economic outcomes, and helping Oregonians live healthier lives.

An important part of the communication strategy was to build a coalition of advocates for the Recommendations from among the representatives of our Collaborative. Given our experience with the endorsement process, we anticipated having greater success getting organizations to adopt the Recommendations when our partners were engaged in bringing the HBOS message to the organizations they represented (see figure below).



HEALTH SYSTEM TRANSFORMATION

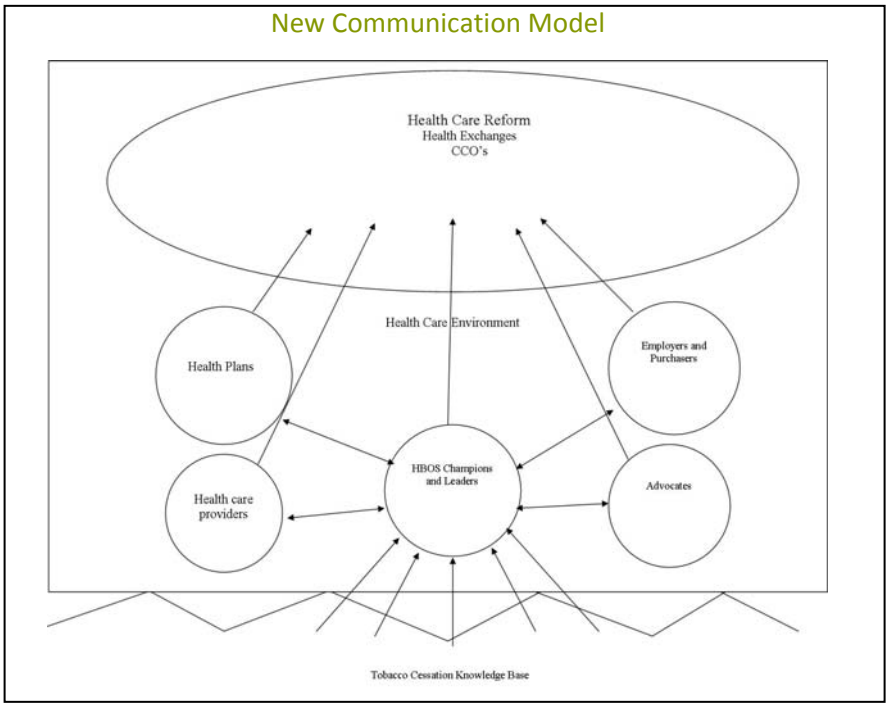
At the time the communication strategy got underway, health care change in Oregon accelerated. Oregon has a history of health care innovation and was early in support of the Affordable Care Act (ACA). With its provisions for Medicaid expansion, the ACA created new opportunities in Oregon for much needed for health care reform and the state quickly began organizing what is known as Oregon's Health System Transformation. A team of 45 people from all aspects of health and health care together with bi-partisan lawmakers was assembled and charged with developing a plan to improve the health delivery system for Oregon Health Plan and Medicaid clients. The plan was to focus on coordinating mental, physical, behavioral, and oral health to free up resources trapped in an inefficient system, increase the focus on prevention, and improve care. The resulting plan called for the restructuring of Oregon's Medicaid system into regional Coordinated Care Organizations (CCO). At the same time, a committee was appointed to develop Oregon's health insurance exchange required under the ACA (Cover Oregon). The future plan is to see if adapting the CCO model for the commercially insured through Cover Oregon can make further improvements in health care.

This massive overhaul of Oregon's health care systems effectively disrupted the health care communication channels normally used and brought the HBOS outreach effort to a halt. With much more fundamental organizational issues to resolve, health plans and health care organizations were preoccupied with overall health care transformation and unable to consider the level of benefit detail that HBOS was addressing.

Despite the overall disruption, it was clear that many new discussions were underway and new decisions were being made creating a potential opportunity to also influence decisions about tobacco cessation benefits. With a heightened emphasis on prevention, both as part of the ACA and as part of the mission of the new Oregon CCOs, the HBOS Recommendations could be usefully integrated into these new discussions and become part of a new set of benefit coverage decisions. But with communication channels disrupted, a new communication model and a new message were needed.

The new communication model acknowledged that many formal and informal healthcare discussions were already underway. To effectively influence this process, the best information about tobacco cessation benefits should be available when questions were raised. The new model moved from a goal to build a coalition of advocates for the HBOS Recommendations to building a coalition of well informed leaders who could participate in a variety of formal and informal discussions (see diagram below). In order to do that, we needed to:

- Help improve the knowledge base of HBOS members so they could respond to questions and contribute to discussions; and
- Develop a better advocacy message in the era of health care transformation and cost containment.



Improving the knowledge base

Several steps were taken to help build the knowledge base of HBOS members:

- New content was developed and added to the website including answers to frequently asked questions and a series of case studies.
  Rationale for case studies: One of the difficulties discussing the Recommendations was making the problem "come alive" so the negative effects of specific features of a benefit design were more understandable. By providing case studies that illustrate the impact of a problematic benefit design from the point of view of patients, physicians, health plans, and employers, it was easier to help build a rationale for each of the HBOS Recommendations.
- New graphics were designed to illustrate the effect of nonstandard benefit design across health plans.
  Rationale for graphic: HBOS health plan members all wanted to know the details of an effective smoking cessation benefit. At the same time, each health plan approached benefit design in a unique way based on internal policies and conventions as well as market standards. As each compared their benefits to the HBOS standard, their interpretation led most of them to agree that they were providing a benefit consistent with the Recommendations. However, when these benefits are placed side-by-side, what emerges is the confusing and contradictory benefit picture that confronts clinicians, health delivery systems, and smokers trying to understand what is actually covered and how. A graphic, based at the time on Medicaid benefit policies (data that was available and more complete) illustrated the problem across health plans and

bolstered the rationale for a common benefit (see Medicaid Tobacco Cessation Services Comparison chart, attached).

- New tools were developed to highlight key messages and to help members simplify their discussions. An important set of tools were the "How Does Your Benefit Score?" worksheets. *Rationale:* In the same way that case studies illustrate the effect of problems in benefit design, the scoring worksheets illustrate the strengths and weaknesses in an existing benefit and show areas where changes could be made. The scoring system made the benefit design comparisons concrete and useful.
- The website was redesigned to make the new information more useful and accessible, adding new tabs and uploading the new tools and fact sheets.
- HBOS meeting agendas shifted to provide more information and discussion around hot topics and developments within health care and the health plans.
- An HBOS list serve was set up to circulate information and provide a forum for discussion.

New advocacy message

A new message was developed to better reach our audiences during the time of Health System Transformation. The new message needed to be able to capture the attention of the highly cost conscious health and health care community and effectively advocate for adopting the Recommendations. The resulting *$400 Million Solution* fact sheet focused on potential cost savings that could occur if quit rates increased as a result of providing an effective standard benefit that was easily accessible. The published results from the Massachusetts benefit experience were used to illustrate the possibilities in Oregon. (See the *$400 Million Solution* and all the HBOS information and tools at www.smokefreeoregon.com/policy/helping-benefit-oregon-smokers.)

RESULTS

Health Plan Survey

A follow-up survey was sent to all the health plans participating in the HBOS project. Of those, we were able to get responses from six plans (See Table 1, attached). While it is not possible to directly compare responses from the baseline survey to the follow-up survey, several of the health plans did acknowledge several important changes in their benefits over the course of the HBOS project. Most notably, the $500 lifetime limits were removed (although Pacific Source still has a two enrollment lifetime limit unless purchasers negotiate otherwise). Other reported changes were ones that reduced barriers, especially those waiving fees for programs and medications, and added services.

The survey information is consistent with the information gathered over the course of HBOS meetings. Health plan representatives regularly discussed changes that were being considered and some were later approved. It is likely that the amount of change is actually greater than reported on the survey because there was substantial turnover among health plan representatives and the new representatives may not have had as much of the previous detailed information about benefits.

These survey results have several key points:

1. Health plans are following many of the Recommendations. The scores range from 61 percent to 83 percent (see attached scoring worksheet). This is a positive finding. However, the absence of follow-up data makes it difficult to evaluate how the Recommendations are being implemented and whether the benefits are working effectively.

2. The health plans generally link access to medications to program enrollment. This link is intended to help health plan members get better care and to make sure that the medications are being used properly. The link is also practical; most health plans do not have an internal program to handle their cessation benefits. Most health plans contract with a vendor and the vendor provides the combined services. In some cases, the requirement to enroll in a program to receive medications can be waived under specific circumstances (e.g. authorization by a primary care provider) and if these medications are included in the formulary. But the single pathway to receive services does impede treatment for some patients. This is especially the case for hospitalized patients who may begin their treatment as inpatients and then do not have a treatment pathway to follow after they are discharged.

   The linked pathway also inhibits access to medications when other self-help approaches to quitting are used. This may become more of an issue with the growth of online programs that have been shown to be effective. Enrollment in programs to stop smoking is substantially less common than using medications to stop smoking. Restricting access to medications to only people who enroll in programs curtails quitting efforts.

3. Health plans are moving towards waiving costs for both program enrollment and medication use. With the implementation of the Affordable Care Act underway, this trend should increase.

4. In some health plans the benefit covering tobacco cessation programs is separate from the pharmacy benefit. A smoker enrolling in the tobacco cessation program may be able to get over-the-counter medications as part of program enrollment but may need to get a separate prescription and use their pharmacy benefit to get a prescription medication. This split in benefits can complicate the process of getting needed medications unless there is an internal process that helps streamline the separate steps.

Employer Survey

The OCHCP survey conducted in late 2009 also gathered information about tobacco cessation benefits offered by Oregon employers. Sixteen employers were targeted, eleven responded with results available from eight of the eleven.

Results for the eight employers are as follows:

1. Two provided tobacco cessation as a benefit; four did not know if there was coverage; and two provide no such coverage.
2. At the time, three employers were aware of the mandate; five were not.
3. Seven employers were interested in offering tobacco cessation coverage; one was uncertain.
4. Seven employers think their employees would consider tobacco cessation as a positive addition to the benefit package; one was uncertain.
5. Employers informed employees about new benefits verbally during employee meetings and through announcements at on-site health clinics. They planned to make tobacco cessation promotional materials available to employees.

A follow-up survey of 25 large and 19 small/medium employers was conducted in October – December of 2012 to determine trends in tobacco cessation benefits in Oregon. Of the large employers contacted, 16 surveys were completed and 3 were completed for small/medium businesses. Two of the large employers were covered under federal health plans and are not included in the results. Two of the medical centers are covered under the same plan and are combined. Three of the state universities contacted are all covered under the Public Employees Benefits Board and were all combined into the overall coverage for the Oregon University System. The results from 11 large employers and three small/medium employers are presented in Table 2 (attached).

1. Most of the large commercial employers had policies prohibiting surveys or did not respond to the requests for information. As a result, much of the data is from public employers.

2. All the employers who did respond offered tobacco cessation benefits. This is a positive finding and is a change from the OCHCP survey results. Two employers, St. Charles and Trimet, were in the process of updating their policies and benefits.

3. All the employers that responded had full or partial bans on smoking in the workplace. The partial bans were on the university campuses; at Trimet, and at Lane Community College. Trimet was in the process of reviewing smoke free policies with a plan to ban smoking in 2013. Lane Community College permits smoking only in designated smoking areas located in their parking lots.

4. The HR person responding to the survey usually only knew the broad details of the benefit. Most benefits were included as part of health plan contracts or, in the case of some of the self insured employers, were negotiated as a separate contract, usually with the telephone services offered

through Alere Wellbeing. The details of the benefit used for generating a score were often derived from the details already available from the health plan survey.

5. The comparison scores for these employers ranged from 45 percent for the attorney group Tonkon Torp to 93 precent for Providence Health Systems (see attached scoring worksheet). The three highest scores are for the three largest health systems, Providence, Kaiser Permanente, and OHSU. Large health care systems have more resources and expertise that may enable them to offer a more comprehensive benefit for their employees.

   Many employers purchase tobacco cessation benefits as part of their contracts with health plans. Because of this, employers are limited to the benefits that the health plan has to offer. These employers might be able to improve their benefits through adjustments in cost sharing and changes in other requirements that are negotiated with the health plan, but may not be able to improve benefits through added services unless the health plan adds these services to the benefit offerings.

CONCLUSIONS

Tobacco cessation benefit coverage in Oregon has improved in the three years since SB734 was implemented. Benefits available through health plans have changed and also improved in quality since 2010. Employers appear to be more likely to provide benefits and to have smoke free policies, both of which encourage quitting. If these trends persist, overall reductions in smoking rates in Oregon could follow.

There are multiple reasons for these improvements. The passage of SB734 clearly influenced benefits offered through Oregon's health plans and, consequently, though employers. The passage of the Affordable Care Act and the Oregon initiative to transform health care has helped to move these health care benefits further along. The intense pressure to reduce health care costs has spurred everyone to look to preventive services as a possible cost saving measure and wellness programs are growing within many worksites. All of this creates a positive environment for potential improvements in tobacco cessation benefit coverage.

The Helping Benefit Oregon Smokers project emerged in the midst of these changes and opportunities. The HBOS project has helped to define recommendations for an effective tobacco cessation benefit capable of helping to reduce smoking rates in Oregon, thereby complimenting the changes already underway. Health plans and employers are adopting aspects of these benefit recommendations and the resulting scoring shows that at least some of the existing benefits compare favorably with the HBOS benefit recommendations. Progress has been made but there is clearly more to do.

A substantial gap in any ongoing benefit improvement is the lack of data about how well any of these benefits are working. Many of the health plans and most of the employers did not have access to any outcome data. In many cases, they did not know the proportion of their employees who smoke or how many of them have enrolled in the benefit to try to quit. While this information may be deliberately confidential for some employers, the lack of information does hinder discussions about quality

improvement. We can solve some of the methodology problems in our research studies, but we cannot undertake meaningful quality improvement without knowing more about the outcomes of the available services.

Another limitation for improving cessation benefits may be within the health plans themselves. Employers mostly purchase health care from the available options health plans offer. While some benefit improvement changes are possible to negotiate in the terms of cost sharing and other benefit requirements, employers cannot purchase more services than are available. This means that the comprehensiveness, and possibly effectiveness, of benefits is restricted somewhat unless new types of services can be developed, streamlined, and provided through the health care delivery system. An example might be smokers with chronic diseases. These smokers need to quit as part of their chronic disease management but the services that are provided for smoking cessation may not be integrated into chronic disease management services. This can leave gaps or contradictions in the care that is given. Another example is hospital patients who receive treatment for smoking while hospitalized, consistent with Joint Commission and Meaningful Use requirements. But when patients are discharged, there is not an appropriate treatment pathway that takes over from the care they received in the hospital. The "one size fits all" approach to tobacco cessation benefits and services is not sufficient to effectively help smokers with these unique circumstances. And, we are seeing that the population of smokers is increasingly one made up of people with unique circumstances.

The Oregon tobacco control story continues to be positive and effective. Oregon has an ongoing opportunity to advance quality improvement of tobacco cessation benefits as well as address some of the gaps in benefits as health care reform continues to evolve. New decisions about benefit coverage and health care delivery are underway; offering a chance to influence how these new systems can help support tobacco cessation. Continuing to address the quality of tobacco cessation benefits, using the HBOS Recommendations and tools can help shape these future decisions and help be part of improving the health and quality of life for all Oregonians.

Helping Benefit Oregon Smokers

Medicaid OHP Tobacco Cessation Services Comparison 2012

Counseling	Proposed Standard of Care	Care Oregon	Cascade Comprehensive Care	DOCS	DCPIA	Family Care	Intercomm Health Network	Kaiser	LIPA	Marion-Polk Community Health Plan
Individual with PCP	*trained*									
Individual with other health professional	*trained*									
Group with other health professional	*trained*									
Group with specific cirriculum	*trained*									
Telephone with vendor	*trained*									
Telephone in house	*trained*									
Medications										
Nicotine Gum								updating		
Nicotine Patch								updating		
Nicotine Lozenge										
Nicotoine nasal spray										
Nicotine Inhaler										
Bupropion SR								updating		
Varenicline								updating		
*1 course =										

Counseling	Proposed Standard of Care	MRIPA	ODS	OHMS	PacifcSource Community Solutions	Providence	Tuality Health Alliance	FFS
Individual with PCP	*trained*							
Individual with other health professional	*trained*							
Group with other health professional	*trained*							
Group with specific cirriculum	*trained*							
Telephone with vendor	*trained*				Avail. in 2012			
Telephone in house	*trained*							
Medications								
Nicotine Gum								
Nicotine Patch								
Nicotine Lozenge								
Nicotoine nasal spray								
Nicotine Inhaler								
Bupropion SR								
Varenicline								
*1 course =								

KEY

- 2 courses/unlmited
- <2 courses/limited
- 2 courses w/PA or requirements
- 1 course w/PA or requirements
- TPEP 1 call
- N/A
- Course = 12 wks
- Course < 12 weeks

Table 1: HBOS 2012 Health Plan Follow-Up Survey

HBOS Recommendation	Providence	Regence	Pacific Source	Cigna	Kaiser	ODS
OUTREACH						
Tobacco used asked at every visit	Yes	N/A	N/A	N/A	Yes	N/A
If positive, referred to programs	Yes	N/A	N/A	N/A	Yes	N/A
Tobacco use identified via HRA, claims data, etc.	Yes	Yes	Yes	Yes	Yes	Yes
If positive, referred to programs	Yes	Yes	Yes	Yes	Yes	Yes
Promote enrollment through member communication	Yes	Yes	Yes	Yes	Yes	Yes
EVIDENCE BASED SERVICES COVERED						
Multiple program options	Yes	No: Phone only	Yes	Yes	Yes	Yes
Programs offered by trained professionals	Yes	Yes	Yes	Yes	Yes	Yes
Multiple medications offered including both OTC and Rx.	Yes	No: Rx only	Yes	No: OTC only	Yes	Yes
Coverage for medication and programs separated.	Yes	Contract terms	No	No	No	No
Medication combinations covered.	Yes	Contract terms	No	No	Yes	Yes
2+ programs annually.	Yes	Contract terms	No	Yes	Yes	Yes*
2+ courses of medications annually (20-24 weeks)	Yes*	Contract terms	No	Yes	Yes	Yes*
REDUCING BARRIERS						
No prior authorization	No	Contact terms	Yes	Yes	Yes	Yes
No program enrollment requirements	No	Contract terms	No	No	No	No
Limited cost sharing	No cost	Contract terms	Yes	No cost	Yes	Yes
Programs	No cost		Group cost share	No cost	No cost	No cost

Table 1: HBOS 2012 Health Plan Follow-Up Survey

Medications	No cost		No cost	No cost	Yes	Yes
No cost sharing	Yes*	Contract terms	Yes	Yes	Yes	Yes
Programs	Yes*		Yes	Yes	Yes*	Yes*
Medications	Yes*		Yes	Yes	Co-pay	Co-pay
NO LIFETIME LIMITS	Yes*	Yes*	2 lifetime enroll	Yes*	Yes	Yes*
% HBOS BENEFIT SCORE	83%	N/A	61%	69%	82%	82%

Notes:
1: * = change since 2010.
2: Health plans did not have good access to outcome data. Therefore, HBOS quality improvement recommendations are not included in score.
3: Four of six health plans do not have control over clinic practice re: asking about smoking at every visit. These two recommendations were deleted in scoring those plans.
4: Benefit coverage for Regence is dependent on a wide variety of contracts. A standard, generalized benefit was not available.
5: Survey conducted September – December 2012.

Table 2: HBOS 2012 Employer Survey Results

Organization Completing Survey	Number of Employees	Insurance Plan	Cessation Benefit Coverage		Tobacco Policy	HBOS Score*
			Counseling	Medications		
Samaritan Health Services	15,000	Self: Contract with Alere	Yes	Yes	Yes	64%
Oregon University System: PEBB	14,463	Self: Contract with Alere	Yes	Yes	Partial – all in 2013	64%
Oregon Health & Science University	14,000	Self: Contract with Alere	Yes	Yes	Yes	87%
Kaiser Permanente	8,900	Kaiser	Yes	Yes	Yes	88%
Rogue Valley Medical Center	3,800	Cigna	Yes	Yes		67%
Providence	3,500	Providence	Yes	Yes	Yes	93%
Trimet	2,500	Kaiser, Regence	Coverage based on health plan		In process	N/A
St. Charles Medical Center	2,400	Self: United Medical Resources	Yes: Group 2013: Add Ind. coaching	Yes: RX only through pharm. benefit. 2013: Add OTC meds through wellness program.	Yes	46% (69% in 2013)
Lane Community College	2,000	Faculty: OEBB Staff: Pacific Source	Yes	Yes	Partial: designated areas	70%
General Sheet Metal	900	Providence Preferred	Yes	Yes	Yes	66%
Portland International Airport	750	Kaiser, Cigna	Yes	Yes	Yes	71%
Tonkon Torp LLP	179	Providence, Kaiser	Yes	Yes	Yes	45%
Vernier Software	95	Providence	Yes	Yes	Yes	65%
Yorke & Curtis General Contractor	30	Pacific Source	Yes	Yes	Yes	60%

helping benefit Oregon smokers

Health Plans: Compare your benefit to the HBOS Recommendations
How does your benefit score?

Points	
	Outreach to smokers (25 points)
5	☐ Tobacco use is asked at every clinic visit for patients 15 or older.
7	☐ Patients who use tobacco are referred to programs for treatment.
4	☐ Tobacco users are identified through health risk appraisals, case management, claims data.
5	☐ Patients who use tobacco receive follow-up invitations for program enrollment.
4	☐ Promote program enrollment through member communications.
	Apply evidence-based treatment best practices modeled on chronic disease management. (35 points)
5	☐ More than one program option is covered: individual and/or group sessions, telephone quitline sessions, online programs.
5	☐ Programs are offered by trained tobacco cessation professionals.
5	☐ Multiple choices of prescription and over the counter FDA approved medications are covered. Selection should include several options to find one that works.
5	☐ Medication coverage and program coverage are offered separately and also in combination to create flexible options.
5	☐ Medication combinations are covered (e.g. nicotine patches and gum together) for flexibility and increased effectiveness.
5	☐ Two or more program enrollments are covered annually.
5	☐ Two or more courses of single or combination medications are covered annually (20-24 wks).
	Reducing/eliminating barriers for easier access. (25 points)
6	☐ Prior authorization is not required for medications.
6	☐ Program enrollment is not required to access medications.
6	☐ Cost sharing is limited to usual co-payments for other routine medical services.
7	☐ Cost sharing is waived to increase participation.
	Measure and review outcomes to help reach goals. (15 points)
4	☐ Physician performance for clinic screening, referrals, & prescriptions is measured & reviewed.
4	☐ Participation rates in stop smoking programs are measured and reviewed.
4	☐ Pharmacy utilization rates are measured and reviewed
3	☐ Member quit rates through 6 months are measured and reviewed.

Total Points

Scoring Key: 85-100 points = Excellent • 75-84 points = Good • 50-74 points = Average • <50 points = Below Average

HELPING BENEFIT OREGON SMOKERS
OHSU Smoking Cessation Center I 3181 SW Sam Jackson Park Rd. CR 115 I Portland Oregon 97239 I 503-418-1659 I bjornson@ohsu.edu
www.smokefreeoregon.com/smokefree-place s/worksites

helping benefit Oregon smokers

Employers: Compare your benefit to the HBOS Recommendations
How does your benefit score?

Points	
	Reaching out to smokers. (25 points)
6	☐ Smokers are identified through health risk appraisals, claims data.
7	☐ Employees who use tobacco receive follow-up invitations for program enrollment.
5	☐ Program enrollment is promoted through employee communications.
7	☐ Employee incentives are offered for enrollment.
	Applying evidence-based treatment best practices modeled on chronic disease management. (35 points)
5	☐ More than one program option is covered: individual and/or group sessions, telephone quit line sessions, online programs.
5	☐ Programs that are offered are provided by professionals trained in tobacco cessation
5	☐ Multiple choices of prescription and over the counter FDA approved medications are covered to create options for finding one that works.
5	☐ Medications and programs are covered separately and also in combination to create flexible options.
5	☐ Medication combinations are covered (e.g. nicotine patches and gum together) for flexibility and increased effectiveness.
5	☐ Two or more program enrollments are covered annually.
5	☐ 20-24 weeks of single or combination medication treatment are covered annually.
	Reducing/eliminating barriers for easier access. (25 points)
6	☐ Program enrollment is easy to access (e.g. one phone call or online registration).
6	☐ Access to medications is easy (e.g. facilitated through program).
6	☐ Cost sharing is limited and similar to other medical services.
7	☐ Cost sharing is waived to increase participation.
	Measuring and reviewing outcomes to help reach goals. (15 points)
5	☐ Participation rates in stop smoking programs are measured and reviewed.
5	☐ Pharmacy benefit utilization rates are measured and reviewed.
5	☐ Employee quit rates through 6 months are measured and reviewed.

Total Points

10	☐ Worksite Smoke Free Policy
5	☐ Policy expanded to prohibit use of all tobacco products

Scoring Key: 85-100 points = Excellent • 75-84 points = Good • 50-74 points = Average • <50 points = Below Average

HELPING BENEFIT OREGON SMOKERS
OHSU Smoking Cessation Center I 3181 SW Sam Jackson Park Rd. CR 115 I Portland Oregon 97239 I 503-418-1659 I bjornson@ohsu.edu
www.smokefreeoregon.com/smokefree-place s/worksites