March 2, 2000

Senate Bill 115 (Robson/Black)

Health Insurance Coverage of Smoking Cessation Treatment

Summary of Bill --

This bill requires health care plans to cover smoking cessation treatments, in conformity with federal clinical practice guidelines and using federally approved medications.

Amendment 1 specifies the breadth of medications to be covered (and passed the committee 4-1 with Moore voting no).

Amendment 2 deletes a once-a-year course of treatment limitation for certain plans, replacing it with a three times a year limit (same 4-1 committee vote).

While there is considerable uncertainty about the cost, Fiscal Bureau's best guess is $1 million/annually to cover state employees. This is a drop in the bucket considering tobacco settlement funds coming into the state. This investment should produce long term savings if successful.

Staff Comments --

Clearly an investment in preventing smoking-related disease. Also worth remembering, you wrote Gard on Oct. 26 to urge action.

Standing Committee Action --

SB115 was approved 5-0 by the Senate Committee on Human Services and Aging on Sept. 23, 1999. As noted above, Sen. Moore voted no on Amendments 1 and 2.

Recommended JFC Action --

Approve bill with amendments.

Bob

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

March 2, 2000

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Senate Bill 115: Health Insurance Coverage of Smoking Cessation Treatment and Medications

Senate Bill 115 was introduced on April 14, 1999, and referred to the Senate Committee on Human Services and Aging. On September 28, the Committee recommended the bill for passage, as amended by Senate Amendments 1 and 2, by a vote of 5 to 0. On October 26, the bill was referred to the Joint Committee on Finance.

SUMMARY OF BILL

Under current law, health care coverage plans offered by the state or the Group Insurance Board, self-insured plans offered by a town board, city, village, or school district, cooperative sickness care plans or voluntary nonprofit sickness care plans, and managed care plans and preferred provider plans must provide certain benefits. Some of these mandated benefits include: (a) home care; (b) skilled nursing care; (c) kidney disease treatment; (d) services for newborn children; (e) services required for covered grandchildren; (f) equipment and supplies for diabetes treatment; (g) maternity services; (h) mammograms; (i) prescription medication for the treatment of HIV infection; (j) blood lead tests for children; (k) treatment for correction of temporomandibular disorders; (l) hospital and ambulatory surgery center charges and anesthetics for dental care; and (m) breast reconstruction incident to a mastectomy. Some of these plans or entities may be subject to more of these mandates than other plans or entities.

SB 115 would add smoking cessation treatment and medication to the list of mandated benefits that certain plans or entities are required to cover. This coverage requirement would apply to the following types of plans: (a) health care coverage plans offered by the state or the Group Insurance Board; (b) self-insured plans offered by a town board, city, village or school district; (c)

cooperative sickness care plans; (d) voluntary nonprofit sickness care plans; and (e) managed care and preferred provider plans. Plans offered by limited service health organizations and disability insurance policies that cover only certain specified diseases would be exempt from this requirement. Employers would be prohibited from bargaining on this provision.

The treatment that is provided would be required to conform to the recommendations set forth in Clinical Practice Guideline Number 18, Smoking Cessation, publication number 96-0692, published by the federal Department of Health and Human Services, Agency for Health Care Policy and Research (AHCPR). This treatment would not have to be provided more than one time in a year, but would be required to provide coverage of all of the following medications prescribed for smoking cessation: (a) nicotine gum; (b) nicotine patch; (c) nicotine nasal spray; (e) nicotine inhaler; and (f) Zyban or its generic equivalent. Coverage of this treatment may be subject to limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured health plan.

According to the AHCPR clinical practice guideline, three treatment elements are particularly effective, and one or more of the following elements should be included in smoking cessation treatment: (a) nicotine replacement therapy (nicotine patches or gum); (b) social support (clinician-provided encouragement and assistance); and (c) skills training/problem solving (techniques on achieving and maintaining abstinence).

The bill would first apply to disability insurance policies that are issued or renewed, and self-insured health plans that are established, extended, modified or renewed, on the first day of the sixth month beginning after the bill's publication. However, for disability insurance policies or self-insured health plans covering employes who are affected by a collective bargaining agreement containing provisions inconsistent with this bill, this bill would first apply to those policies or plans that are issued, established, extended, modified, or renewed no earlier than the first day of the sixth month beginning after the bill's publication but after that date, on the earlier of: (a) the day on which the collective bargaining agreement expires; or (b) the day on which the collective bargaining agreement is extended, modified or renewed.

SUMMARY OF SENATE AMENDMENTS 1 AND 2 TO SB 115

SA 1 to SB 115 would specify that every disability insurance policy and every self-insured health plan must provide coverage of: (a) nicotine gum; (b) nicotine patch; (c) nicotine nasal spray; (d) nicotine inhaler; and (e) Zyban or its generic equivalent only if those medications are approved for use by the federal Food and Drug Administration and if prescribed for smoking cessation.

SA 2 to SB 115 would delete the provision that would specify that disability insurance policies or self-insured plans do not have to cover a course of treatment more than one time in a year. Instead, SA 2 to SB 115 would specify that disability insurance policies or self-insured plans would not be required to cover smoking cessation treatment more than three times for any insured.

FISCAL EFFECT

Estimated Benefit Costs for State Employes. The Department of Employe Trust Funds (DETF) submitted a fiscal note to the bill that estimated the cost of providing coverage for smoking cessation and treatment to state employes would be approximately $1.8 million (all funds) annually. DETF developed this estimate by multiplying the total estimated number of adults covered under the state employe group health insurance program (approximately 120,000) with the estimated number of state employes who smoke (25%), then multiplying that number (30,000) with an estimate of the percent of smokers who would participate in a smoking cessation and treatment program (5%) and an estimate of the average costs of a course of treatment ($1,200 per individual).

Based on the amount of funding, by source, budgeted for compensation reserves in 1999 Wisconsin Act 9 (the 1999-01 biennial budget act), the distribution of these costs between fund sources would be approximately 45% GPR, 34% PR, 13% FED and 8% SEG. Due to the initial applicability provision in the bill, the new benefit would first be available in calendar year 2001 state employe contracts which would begin October 1, 2000. Consequently, based on the assumptions used by DETF, it is estimated that the additional costs of treatment would be approximately $538,200 GPR, $417,200 PR, $153,000 FED and $96,100 SEG in 2000-01. Beginning in 2001-02, the annual costs of providing this benefit would be approximately $807,300 GPR, $619,000 PR, $229,000 FED and $144,200 SEG.

It is possible that the DETF fiscal note overestimates the average cost of a course of treatment. DETF assumed a smoking cessation course of treatment would cost $1,200 per participant, based on information provided by the agency's consulting actuary. This estimate includes an intensive counseling component. DETF staff indicate that, although SB 115, at a minimum, would require nicotine replacement therapy, many managed care organizations would incorporate a counseling component into their treatment programs. DETF further argues that if one removed the intensive counseling component from its estimate, the percentage of smoking cessation treatment participants would increase significantly.

The Director of Pharmacy Services at Physicians Plus agrees with DETF's assumption that, without intensive counseling, the number of participants in a smoking cessation treatment program would likely be greater than the 5% assumed by DETF. This individual suggested that the percent of smokers who would participate in a program that did not offer intensive counseling could be as high as 20% initially, then drop to half that percent by the end of the first year.

When Physicians Plus offered nicotine replacement therapy without counseling a few years ago, the program's cost totaled $300,000 in the first six months. As a result, Physicians Plus modified its smoking cessation treatment program. The current smoking cessation treatment program costs Physicians Plus $15,000 per year and reimburses its members for the cost of a nicotine patch for up to 90 days per year only if the patient attends three individual or four group counseling sessions (for which the patient is also reimbursed). A Physicians Plus official states that

its current smoking cessation treatment program costs between $600 and $800 per participant and has a "quit rate" of approximately 20%.

If one assumes that other managed care organizations would offer programs that are similar to the program currently offered by Physicians Plus, with an average cost of $700 per participant (rather than $1,200 per participant as assumed by DETF), the estimated annualized costs would be reduced by approximately 41% from the DETF estimate, to approximately $1,050,000 (all funds) annually.

According to the Director of the Center for Tobacco Research and Intervention (CTRI) at the University of Wisconsin Medical School, the typical range for the actual cost of effective smoking cessation treatment (in conformity with the AHCPR guideline) would be $250 to $400 per participant. These costs would include two to three months of nicotine replacement therapy and one to two brief counseling sessions (requiring three minutes or less of direct clinician time). The CTRI Director indicates that intensive intervention is not necessary for an effective smoking cessation treatment program. Consequently, assuming a 5% participation rate, one could reestimate DETF's annual cost under SB 115 to be $450,000 (30,000 employes x .05 x $300 per employe). However, if one accepts the arguments presented by DETF and Physicians Plus that a program that offers minimal counseling would increase the number of program participants, it may be appropriate to assume a 10%, rather than a 5%, participation rate, in which case the estimated annual costs for providing the benefit to state employes would be approximately $900,000.

In summary, although there is considerable uncertainty over the actual average costs and demand for the new benefit, it would be reasonable to estimate that the average annualized cost to provide the benefit to state employes would be approximately $1,000,000 per year (all funds).

The DETF fiscal note recognizes, but does not estimate, the potential future cost savings that would result from reduced use of health care services. The U.S. Centers for Disease Control and Prevention indicates that tobacco use is the single most preventable cause of death and disease in the United States. Based on the 20% "quit rate" experience of the Physicians Plus program, it appears that providing such a benefit could reduce, in future years, overall health care costs for state employes.

Regulation. The Office of the Commissioner of Insurance (OCI) submitted a fiscal note to the bill that indicated that OCI would absorb any additional cost of reviewing health insurance policy forms to ensure that they comply with the new requirements contained in the bill. OCI staff expect to release the agency's social and financial impact statement on the proposal that is referenced in the agency's fiscal note during the week of February 28. Consequently, Committee members may have this information available at the Committee's March 2 meeting.

Prepared by: Barbara Zabawa