Managed care and the state tobacco settlements

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Legislatures around the country are deciding how to spend the impending avalanche of tobacco settlement money. This avalanche has the capacity to be a boon for tobacco control or a boondoggle. Hundreds of billions of dollars will flow into states for 25 years. Nobody knows whether this money will go for road repair, general fund bailouts, education, medical services, or tobacco control. If settlement money is not allocated to tobacco control now, it will be difficult to recapture it in future years.

Managed care organisations (MCOs) have a role to play that can be very positive or potentially negative. We are large businesses with a legitimate stake in this issue. We pay for tobacco related care, even more than the states do. We will be affected by how cessation services are provided as well.

We also have some quirky incentives. MCOs can obtain immediate direct financial gain from government spending that expands reimbursement for medical services. However, any financial benefits to us resulting from population level activities, such as media or community campaigns, are more intangible. There have been disturbing experiences, such as the California Medical Association lobbying to take money *away* from tobacco control in order to place it into medical service programs that involved direct remuneration to physicians. Within tobacco control, if we lobby to use this money only to pay for formal smoking cessation programs, physician visits and pharmaceuticals, we might decimate funding for school and community programs, as well as public education campaigns that lead to more adults quitting smoking. If we want someone else to pay for our members' cessation services, perhaps we should sue the tobacco industry directly. Minnesota Blue Cross/Blue Shield actually did, and won hundreds of millions of dollars which they will devote to health improvement and reducing tobacco use. Other plans in Minnesota and elsewhere are following suit.

Alternatively, experience indicates that health care systems and providers are having a hard time getting things going in terms of implementing the Agency for Health Care Policy Research (AHCPR) cessation guideline and providing comprehensive coverage. Figuring out ways to use some settlement money to catalyse the building of a robust cessation infrastructure within health systems is legitimate and important work. Government insurance programs for the under served such as Medicaid must begin providing full cessation support.¹

It is possible for MCOs to make a significant impact on smoking. At Group Health we went from 180 people a year using our cessation program in the early 1990s to 3500 people in

the past year, which is over 8% of our smokers. We are actually creating a public health effect, as we have seen a decline in smoking prevalence in our population compared to Washington state.²⁻⁴

Managed care organisations are gradually improving. As we do, we are discovering it can be as hard for us to change our behaviour as it is for smokers to change. It takes five to seven years for most smokers to move from precontemplation to actually quitting. It is certainly taking us that long. One rate limiting step is resources. Group Health spends over a million dollars a year on cessation services (behavioural support and pharmacotherapy). However, it has become harder in the last few years for health plans to invest in tobacco cessation because of increased industry competition.

There are some things money cannot buy. We need commitment to science and to achieving real measurable outcomes. We need commitment to repetitive improvement cycles and firm support from top leadership in our organisations.

Managed care organisations can also influence policy at the state level. In Washington state, health organisations, voluntary and state agencies, and tobacco control groups set up a task force sponsored by our attorney general, to develop a comprehensive plan. We created the Washington Alliance for Tobacco and Children's Health to perform lobbying and media advocacy. With our attorney general, we were able to convince our governor to support a plan⁵ calling for devoting half the money for the first biennium to a tobacco trust account (the Washington state legislature created a tobacco trust account for \$100 million, devoting the rest to extending medical coverage to the under served).

Every state is struggling over what to do with this money. As illustrated in Washington, it is possible for MCOs to work with others to influence the course of events toward a positive tobacco control outcome. This requires obtaining a sufficient quantity of money, and support for a multifaceted, evidence based tobacco control program.

- 1 Barker DC, Orleans CT, Schauffler HH. Tobacco treatment services should be covered under Medicaid. *Tobacco Control* 1998;7:92-3.
- 2 McAfee TA, Thompson RS. Improving community-based prevention by transforming managed care organizations into health improvement organizations. *J Public Health Management Practice* 1998;4:55-65.
- 3 McAfee TA. Waking the health plan giant: Group Health cooperative stops counting sheep and starts counting key tobacco indicators. *Tobacco Control* 1998;7:S41-4.
- 4 Curry SJ, Grothaus LC, McAfee TA, et al. Utilization and cost-effectiveness of smoking cessation services under four insurance coverage structures in a health maintenance organization. *N Engl J Med* 1998;339:673-9.
- 5 Washington State Attorney General's Tobacco Task Force. A comprehensive tobacco prevention and control plan for Washington State. November 1998; Office of the Attorney General/Highways-Licenses Building/PO Box 40100/Olympia WA 98504-0100.

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