Leading the Way Against the Leading Preventable Cause of Death

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Tobacco use is the leading cause of preventable death and disease in the United States. More than 440 000 deaths each year in this country are attributable to tobacco use, exceeding the combined total from alcohol, street drugs, firearms, motor vehicle accidents, and HIV/AIDS.[1] Approximately one third of all tobacco users in the United States will die prematurely because of tobacco dependence. Despite their awareness of the clear connection between tobacco use and negative health consequences, millions of tobacco users are unable to overcome their nicotine dependence. As a result, tobacco use costs the United States more than $150 billion each year, including over $75 billion in healthcare costs for a wide range of tobacco-related diseases.[1]

These well-established facts would suggest that tobacco control should be a major focus of every managed care organization (MCO) that takes seriously the task of improving the health of its enrollees and containing the costs of health services. Recognizing the importance of tobacco control in managed care, the current issue of the *Journal* extends the scientific evidence for managed care decisions. In this issue, Solberg and colleagues investigate the critical questions about guidelines for treatment of tobacco dependence and how they are understood and implemented in 9 MCOs that have made commitments to tobacco control. The authors conclude that the level of implementation and maintenance of practice cessation supports are both variable and suboptimal.[2] Also in this issue, Javitz and colleagues look to refine the protocol for cost-effective treatment of tobacco dependence using different combinations of behavioral and pharmacotherapy. Their study further supports the conclusion that these interventions are among the most cost effective of life-saving medical treatments.[3]

Yet tobacco control remains far from a central commitment in most MCOs. In 2002, the American Association of Health Plans surveyed 152 health plans representing more than 33 million lives. They found that 72% had written guidelines for smoking cessation, 89% or fewer fully covered various pharmacotherapies, 51% fully covered telephone counseling, but only 19% had at least 1 part-time staff person responsible for tobacco control.[4] Most indicators showed improvement from previous years but continued to demonstrate limited commitment.

Several common concerns may be responsible for MCOs not taking on this problem. First is the perception that tobacco use is a "social problem" and solving it is the role of health departments. Second is the difficulty MCOs have in influencing providers to prioritize prevention, including tobacco control. Finally, many MCOs find that purchasers and benefits consultants remain uncertain about the return on investment (ROI) for tobacco control.

Is Tobacco Control Part of an MCOs Mission?

Most MCOs see their responsibility not only to provide healthcare and contain costs, but also to improve the health status of their populations.[5] However, the administrative claims data used to measure health status in these populations often fail to identify the root causes of diseases brought on by health risk behaviors such as tobacco use, physical inactivity, and poor nutrition. As such, many things are unaccounted for. One way to overcome this may be to adopt a broader vision that encompasses the causes as well as the consequences of the diseases MCOs pay to treat. Some proponents of managed care have even argued that since MCOs suffer the consequences of unresolved public health problems they must share the responsibility for safeguarding the public's health.[6] This was part of the rationale that in 1994 led Blue Cross and Blue Shield of Minnesota to sue the tobacco industry together with the State of Minnesota.

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Health promotion is consistent with the MCO mission to improve health and control costs. Even more, MCOs are in a unique position to reduce tobacco use. Unlike almost any other type of organization, MCOs have the diverse skills and expertise needed to lead in the effort to control tobacco use. Possessing expertise in public policy, health communications, work site health promotion, and clinical systems improvement, MCOs are able to implement a comprehensive model of tobacco control, encompassing policy advocacy, clinical improvement, and community participation.

Can MCOs Make It Happen?

Managed care organizations have long recognized that they must assume a leadership role to improve clinical practice, and they are leading the transition from highly fragmented healthcare to a more integrated healthcare system built on population-based clinical practice.[7,8] Some MCOs have experimented successfully in applying managed care methods (ie, benefit design, financial incentives, and performance feedback) to encourage prevention among providers.[9] Leadership by committed champions cannot be underestimated.[10] The challenge is to move primary care to a point where tobacco dependence is treated as a chronic condition, akin to hypertension, so that providers intervene with all tobacco users at every opportunity.[11,12] Solberg et al illustrate the extent of this challenge in their current paper. However, at the same time that MCOs work with providers to improve preventive care, these organizations can also approach their members directly with proven techniques such as telephone-based cessation counseling.[11] This method is popular and offers smokers convenience and tailored, state-of-the-art cessation counseling.

Is There an ROI?

Strong evidence exists demonstrating that tobacco cessation and prevention are among the most cost-effective measures available to society. Whether measured in cost per life-year saved, cost per quality-adjusted life years, or cost per quitter, the cost effectiveness of smoking cessation compares favorably with other widely accepted preventive services. Modifiable health risk behaviors such as smoking have been studied prospectively and account for 18% higher healthcare costs among adults age 40 and above.[13] These results provide evidence that reducing these health risks may offer MCOs relatively short-term returns on investments for persons in this age group. From an employer's perspective, the ROI from funding a cessation program may be even more significant. One analysis suggests a "break-even" point of just over 3 years, and ultimate returns of more than 8 to 1.[14]

How Should MCOs Address Tobacco in Managed Care?

There is strong consensus on recommendations for treatment of tobacco dependence in the clinical setting. Clinicians are encouraged to follow the 5 "A's" (ask, advise, assess, assist, arrange) with their patients.[11] We propose the 5 "C's" to guide health plans to full engagement in effective tobacco control.[15] In contrast to the 5 A's, which focus on the clinical environment, the 5 C's address a broad spectrum of activity in clinical, community, and public policy arenas. The five C's are described briefly below.

1. **Cover effective treatments.** Health plans should routinely provide benefit coverage for behavioral and pharmacological treatments that work.
2. **Counsel members who smoke.** Health plans can provide access to behavioral counseling, particularly by telephone, which provides low-cost, state-of-the-art care to patients.
3. **Capitalize.** Health plans won't realize an ROI if no investment is made. A comprehensive tobacco control program will require a significant investment of staff and budget in order to succeed.
4. **Collaborate.** Health plans need to work with other organizations that share the goal of reducing tobacco use. The most important work of tobacco control takes place in policy arenas. Among the most powerful tools to reduce tobacco use are increases in tobacco taxes and clean indoor air laws.[16] Health plans must join, and at times lead, coalitions of health and community organizations to advocate for effective public policy on tobacco control.
5. **Count.** Health plans should measure their progress in providing treatment to tobacco users. Tobacco control programs can demonstrate their added value by documenting their successes.

With the insights offered by each new published article, the means to implement effective tobacco control becomes clearer. What is also clear is that the motivation to achieve this control is needed in equal measure. As Roselyn Payne Epps observed, "There has to be a commitment to treat smoking cessation as a priority and MCOs must want to support that commitment. Unless that commitment is there, it's not going to happen."[17] We agree, and suggest that leadership in tobacco control is in the best interest of every MCO as well as of our society.

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