Meeting the Tobacco Cessation Coverage Requirement of the Patient Protection and Affordable Care Act: State Smoking Cessation Quitlines and Cost Sharing

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Objectives. We explored whether various key stakeholders considered cost sharing with state telephone-based tobacco cessation quitlines, because including tobacco cessation services as part of the required essential health benefits is a new requirement of the Patient Protection and Affordable Care Act (ACA).

Methods. We analyzed qualitative data collected from interviews conducted in April and May of 2014 with representatives of state health departments, quitline service providers, health plans, and insurance brokers in 4 US states.

Results. State health departments varied in the strategies they considered the role their state quitline would play in meeting the ACA requirements. Health plans and insurance brokers referred to state quitlines because they were perceived as effective and free, but in 3 of the 4 states, the private stakeholder groups did not consider cost sharing.

Conclusions. If state health departments are going to initiate cost-sharing agreements with private insurance providers, then they will need to engage a broad array of stakeholders and will need to overcome the perception that state quitline services are free. (*Am J Public Health.* 2015;105:S699–S705. doi:10.2105/AJPH.2015.302869)

The most recent Surgeon General's report *The Health Consequences of Smoking—50 Years of Progress* documents that nearly 42 million adults continue to smoke cigarettes, and the report estimates the current annual smoking-attributable mortality in the United States to be 480 000.[1] These mortality rates are preventable, and tobacco cessation treatment has been rated as one of the most effective preventive health services by the US Preventive Services Task Force.[2] Therefore, it is not surprising that tobacco cessation services were included as a tenet of the Patient Protection and Affordable Care Act (ACA; Pub L No. 111–148).

One requirement of the ACA is that health insurance cover essential health benefits such as preventive services, wellness services, and chronic disease management. Under the ACA, tobacco cessation is included as a required preventive service with no copay. The new law places the financial responsibility for providing tobacco cessation treatment on the insurer or health plan, at no cost to the patient, beginning in 2014.

For the past decade and before the ACA, state health departments, service provider organizations, and other national organizations have collaborated to establish a network of state-based quitlines across the United States.[3] Tobacco cessation quitlines are telephone-based programs considered to be an effective approach to cessation.[4–6] The state quitlines offer telephone counseling, medications, information, and other support to help tobacco users quit and to comply with standards set by the US Public Health Services clinical guideline. Currently, state quitlines exist in all 50 states, the District of Columbia, Guam, and Puerto Rico. The median total quitline spending for fiscal year 2013 was $1.7 million.[7] Although the majority of financial support in 2012 was provided by state governments (77%), approximately 18% was provided by the Centers for Disease Control and Prevention (CDC), and 2% came from noteworthy new sources and cost-sharing agreements with third parties such as health plans, employers, and Medicaid.[8]

As implementation of the ACA moves forward, there are a number of potential implications on tobacco cessation services in general[9] and of state quitlines in particular. Because private health plans are now required to include cessations services and because state quitlines have already been offering evidence-based cessation services for a decade, whether there will be cost sharing between state health departments and private health plans is an open question. We refer to cost sharing as the option for a health plan or employer to pay the costs (or some portion of the costs) of providing the state quitline service to their population of quitline users. Cost sharing can take many forms. For example, currently there is at least 1 agreement between a quitline and a health plan for the health plan to cover 100% of quitline costs for plan enrollees. Examples of 50/50 agreements between a quitline and employer groups also currently exist, in which each covers 50% of counseling and therapy costs.

However, cost sharing is not the only option for health plans or employers. Both could bypass states by contracting directly with quitline service providers or they could bypass existing quitlines altogether and find an alternative way to meet the ACA requirement. However, cost sharing may be a more attractive option to a health plan or employer because the cost of state quitline services would be at a reduced rate compared with what they would pay in a direct contract. This is especially true if the state is willing to pay for the administrative costs of the quitline service or for the promotion of the quitline to tobacco users in the state.

Therefore, our aim in this study was to explore the ways various key stakeholders involved in providing coverage for tobacco

cessation services are grappling with how to meet the new requirements of the ACA. Specifically, we were interested in whether and to what extent private health plans are considering cost sharing with the state quitline.

METHODS

Our study team included the 3 authors and 4 North American Quitline Consortium staff members. In April and May 2014, we conducted a small comparative case study using key informant interviews from 4 stakeholder groups within 4 states. When we selected the states, certain characteristics were held constant while allowing the focus to be on variations among several key differences between the states.[10,11] The 4 states we selected all had federally facilitated marketplaces,[12] but varied by strength of state investment in the quitline, approximate percentage of budget provided by CDC funding, level of initial state engagement in cost-sharing agreement activities, adult tobacco use prevalence, and adequacy of state Medicaid coverage for cessation treatment. Two of the quitlines were funded primarily by tobacco settlement funds, 1 was funded primarily by CDC support, and 1 was funded by state and CDC funds. Two of the quitlines were located in the northeast region of the United States, 1 in the midwestern region, and 1 in the southwest. Table 1 provides details about the characteristics of each of the states selected.

We selected 4 stakeholder groups from each state, which included the current funders of state quitlines (i.e., state health departments), the operators of state quitlines (i.e., quitline service providers), the organizations deemed responsible for providing cessation services under the ACA (i.e., health plans), and the organizations that advised health plans and employers about health care coverage (i.e., insurance brokers). We identified key informants for each stakeholder group in each state and gathered their contact information. A letter inviting them to participate in the study was sent via e-mail, and the interviewer responsible for each stakeholder group followed-up on the letter to schedule interviews. Because of long-standing relationships between the study team and the health departments and quitline service provider organizations, identifying and securing interviews with appropriate representatives from these 2 stakeholder groups was relatively straightforward.

We invited and interviewed the tobacco control manager, chief, or the cessation coordinator at the health departments and the most senior client manager or a business executive at the quitline service provider organizations. Securing interviews with health plans and insurance brokers was more difficult, and involved online research to identify the largest insurance companies, based on the most covered lives in that state, health plans, and insurance brokers. We began with the largest organizations, and it typically took many invitations before at least 1 interview was secured. The largest organizations were targeted because they were representative of the coverage that a larger percentage of the state residents were receiving. The long-standing relationships between our team and the health departments and quitline service providers made access to an open dialogue easier for these groups; this was not true for the health plans and brokers. Therefore, there was a need for caution in interpreting responses from the different groups.

We developed an interview guide for each stakeholder group, and 1 interview team member conducted all interviews for each stakeholder group. The interview team included 4 interviewers, 1 for each stakeholder group, as well as 2 note takers; each note taker was responsible for transcribing and summarizing the interviews for 2 stakeholder groups. Each interview was scheduled for 60 minutes, but the actual time varied from 40 minutes to 1.5 hours.

We attempted 2 health plan interviews and 1 interview with each of the other 3

TABLE 1—Characteristics of States Selected: April–May 2014

Characteristics	State 1	State 2	State 3	State 4
State investment in quitline (state dollars invested in quitline per smoker residing in-state)[8]	5.00–9.99	10.00–14.99	0.00–0.99	1.00–4.99
Centers for Disease Control and Prevention funding, approximate % of Quitline budget	5	0	100	50
Level of state engagement in cost-sharing activities hosted by North American Quitline Consortium (based on participation in cost-sharing partnerships or Medicaid work)	Medium-high	Low	Low	High
State tobacco use prevalence[a] (based on state rank according to Behavioral Risk Factor Surveillance System prevalence rate)[13]	Very high prevalence	Moderately high prevalence	Very low prevalence	Low prevalence
Adequacy of state Medicaid coverage for tobacco cessation (based on top rating of 9 areas of coverage)[14]	Good coverage	Inadequate coverage	Inadequate coverage	Good coverage
Service provider	Large, multistate quitline operator	Single state quitline operator, based at health institution	Small, multistate quitline operator, based at health institution	Single state quitline operator, based at university

[a]State prevalence rates were categorized by comparing with the national prevalence rate and the degree to which the state rate was higher or lower than the national rate (21.2).

stakeholders for each state. However, all attempts to secure an interview with a health plan in state 2 and a broker in state 3 were unsuccessful. A few interviews included 2 individuals, from the same organization but in different roles, for a total of 17 interviews being conducted with 23 individuals. Table 2 lists the details about the interviews.

The interviews were analyzed by 2 members of the study team independently to identify key points that emerged from the interviews, including similarities and differences within and across stakeholder groups and within and across states. We then cross-validated the key points separately extracted by these 2 individuals. The results were also reviewed and discussed by the full project team.

RESULTS

A brief overview of each state is presented in the following, followed by additional key points extracted by the stakeholder group not represented in the state descriptions. Table 3 provides supporting quotes for discussion of the key points.

States 1 to 4

State 1 had a proactive state strategy, although efforts to transition to ACA were delayed because of the lack of support for the ACA at the state level. The state health department representatives were highly knowledgeable about ACA, and leadership had an articulated vision for the state quitline in the implementation of ACA that entailed moving to cost sharing. The articulated vision of the state health department entailed the health department leading the initiative and initiating cost-sharing agreements; the service provider for the quitline was asked not to initiate any direct contracts with health plans in the state. Health plans in the state were familiar with the state quitline and were engaged in cost sharing. The state will provide more intensive services to the uninsured and Medicaid, and plans to continue funding the state quitline with few concerns about sustainability.

Informants in state 2 were not very knowledgeable about the ACA. However, the health plan perspective was not represented for this state. There was very little initiative by the state

TABLE 2—Individuals Interviewed, Titles, and Organization Characteristics, April–May 2014

Characteristics	State 1	State 2	State 3	State 4
State health departments	Bureau Chief, Bureau of Tobacco and Chronic Disease, and Chief, Office of Tobacco Prevention and Cessation Programs	Prevention Team Leader, Chronic Disease Division, and Senior Program Manager, Centers for Disease Control and Prevention	Acting Director, Chronic Disease Prevention and Control Services and Manager, Office of Tobacco Control Chronic Disease Prevention and Control Services	Interim Director, Community Development Service and Executive Director, Tobacco Trust
State quitline service providers	Director and Manager, Community Development	Executive Director	Director	Senior Client Services Manager
Insurance brokers	Certified corporate wellness specialist and coach	In-house producer	No Interview	Producer
	Variety of clients: 65% small to medium (50–100 lives), 35% larger (500–4500); public and private employers	Large agency; variety of clients (< 10 employees to large employer groups); public and private employers		Mostly < 100 employees; private companies, mainly construction and some manufacturing
	Variety of plans: high deductible self-funded to fully insured			Fully insured plans
Health plans (1)[a]	Marketing and Communication Account Manager	No Interview	Chief Operating Officer	Senior Plan Analyst
	Nonprofit Medicaid plan serving > 300 000 members		Co-op established through the Affordable Care Act; Individual and Small Group clients (3–10 000 lives); mostly Exclusive Provider Organization (EPO) plans	Approximately 170 000 individuals covered; insure state educational and state and local government entities (1–30 employees)
Health plans (2)[a]	Wellness Consultant	No Interview	Manager, Wellness Clinical Services	Health Promotions Coordinator and Health Promotions Manager, single agency solely responsible for administering the Medicaid program in the state
	Large agency; variety of public and private clients, variety of industries		Mostly midsize group clients (average 300–500 lives); approximately 50% public, other 50% variety of private industries	

[a]Since interviews were attempted with 2 different health plans in each state, (1) and (2) are used to label the different health plan representatives.

TABLE 3—Perspectives on Cost Sharing: April–May 2014

State	State Department Strategy	Role of Service Provider	Private/State Quitline Relationship
1	SH: Yes, regardless of the ACA, we ask the insurers to at least cover the drugs and the next step is the quitline. We show what "no action" on cessation is costing those groups and then talk about the cost of evidence-based treatment and implementation.	SH: [Service Provider] would be more than willing to come in to make the pitches to employers and insurers with direct contract, not cost sharing, in mind. P: When an employer or other organization reaches out to us we also describe our "direct contract" option, meaning no cost share; they won't piggyback off the quitline service. . . . We want to make sure when those groups reach out to us that they are aware of the benefit of a direct contract.	HP1: Use the state quitline and pay for any services not covered by the state quitline B: I do know about our own state quitline. People ask me about it and I do give them that since it's free.
2	SH: We will support [Service Provider] to pursue building those [Health Plan] relationships.	SH: [Service Provider] has relationships with insurers already and it made the most sense to have them pursue those relationships further. P: We will [encourage health plan contracts]. We have not as of yet. The state is in the process of finalizing an interagency agreement for counseling reimbursement for Medicaid populations. Once that's implemented, my plan is to encourage the payers to do the same, as a sustainability initiative.	B: Not familiar with state quitline.
3	HP: Currently waiting on the commissioner to give guidance on next steps; currently in the planning stages and hope that this [cost sharing] is the direction we are heading.	SP: There has been a lack of vision at the state level with respect to cost sharing with the state plans. The state has this quitline program and for me as a vendor to say "hey you want to do cost sharing"—without the state, it doesn't work.	HP1: [State] quitline is free of charge and not sure what kind of partnership we can be engaged in which will have a cost associated with it. HP2: One of the reasons why the nurse practitioners refer clients to the quitline is because of the recognition of them being evidence-based tobacco cessation service.
4	SH: We are trying to encourage pilots and trials for insurers with the intent that the quitline will have its own financial engagement with these insurers—that the cost sharing would be between [Service Provider] and the private insurer.	P: [State Health] has put an edict out that for 2 years [they] are willing to pay for quitline services for anyone. We will provide reporting, including to health carriers and employers. The message is to use the quitline service and see what it provides, then in 2 years you can pay if you like it. So we have 5 employers who have signed up who have built this into their benefits package to save costs.	B: I am exceptionally impressed with our state quitline. Also each employer can setup an account with [State Quitline], and they can get info on where their employees are registered with the quitline, so they can see what benefit the quitline is providing to their employees. HP: We are using the service [state quitline] at no fee. We had some conversations beyond that, but one of the key components is individual level reporting that is needed prior to driving calls to the quitline and we want to overcome that hurdle before we have cost-sharing discussions.

Note. B = Insurance broker; HP = health plan representative; P = quitline service provider; SH = state health department.

health department to develop relationships with the private sector, and the assumption was that the quitline service provider would develop those relationships. The broker representative indicated many very small employers (fewer than 10 employees) in the state; thus, the state's approach of relying on the service provider might be reflective of its employer base.

The state health department perception was that there would be no need to change its quitline service level or eligible populations as a result of ACA. There was very little concern about sustainability of the state quitline, which might be explained by the secure funding of the state quitline in that state. The overall comfort with the current system and the security of funding might partially explain the lack of effort at any change initiatives caused by ACA.

The state planned to continue offering counseling and to begin asking private plans to cover the cost of medications. No time frame was set for moving toward cost sharing for medications, and it was unclear whether the state health department or the service provider would be responsible for working with private plans on cost sharing for medications.

Overall, informants in state 3 were not very knowledgeable about ACA or tobacco cessation. The health department had a more traditional bureaucratic structure and was dependent on political leadership for developing strategy. The state had only CDC funding for the quitline and no state funds were provided, which might partially explain the lack of initiative regarding the quitline and ACA. Overall, there seemed to be very little support for

cessation services in this state, and there was little autonomy for civil servants to make changes. The state quitline was perceived by the other stakeholder groups as an important player in providing services because they offered evidence-based services that were "free." Health plans referred to the quitline, but there was no incentive for cost sharing.

State 4 had proactive top leadership at the health department and was using ACA as an opportunity to improve systems, improve access, and incentivize cost sharing to lead to a more sustainable funding strategy of the state quitline in the future. Their approach was to initiate pilot programs and provide quitline services to any carriers and employers for 2 years so they could see the benefit and then move into cost-sharing arrangements. The quitline service provider for state 4 was a partner in implementing this strategy. The expectation was that the quitline would be self-sustaining in 5 years, and that at that point in time, the state would only be covering the costs of the uninsured, underinsured, and those with Medicaid. However, there was no guarantee that private clients would pay in 2 years, and because the state lacks insurance regulatory authority, the state's approach has to be incentive based.

Health Departments and Service Providers

All informants indicated that the Medicaid offices were an important stakeholder to engage, but the 2 proactive departments also indicated the need to engage with a much broader community, including health plans, broker groups, and associations. Having adequate resources for pursing and maintaining cost-sharing initiatives was an area of concern for those states that attempted cost-sharing initiatives. It was also expressed that data capacities of the quitlines need to be maintained and built into cost-sharing agreements as an incentive to sustain engagement of the health plans. All the health department representatives had the perception that employers would only do what was required and in the cheapest way.

Service provider responses were consistent with their health department counterparts in many aspects, but the provider perspectives seemed to vary by their "characteristics" as providers. The single state service provider in state 4 was working closely with the state health department to develop and implement the cost-sharing plan, whereas the very large, multistate service provider in state 1 viewed states engaging in cost-sharing partnerships with the private sector as competition for its direct contracts. In state 3, a small multistate service provider based at a health institution expressed that they wanted the state to take a leadership role with regard to cost-sharing initiatives, but the state had not done so as of yet. In state 2, where service was provided by a very large health system (single state provider), the service provider, like the state, did not foresee any future changes in the population they would be serving or the intensity of services. Overall, the state tobacco control program was driving the vision and the role of the service provider, and that vision seemed to depend on the type of provider, whether the service provider was perceived as more of a partner or competitor.

Service providers were a knowledgeable "in-between" group; they recognized the constraints of both health departments and health plans, and the importance of employers for pushing insurers to offer what they wanted. There was a great concern expressed about possible decreases in the levels of funding from states. It was also noted that maintaining data capacity also meant discussions about what data to collect because of the differences between what states wanted and what health plans and employers wanted.

Health Plans

Five of the 6 health plan informants were aware of ACA and its requirements, and relied on internal resources with expertise on the ACA. These 5 informants thought services were already in compliance with ACA, but that ACA would increase access because of the uninsured and because of the incentives it required. Health plans representatives noted that many employers were competing for "good" employees and recognized the need to offer services, such as preventive services to keep those good employees happy. Health plan staff perceived their role as educating clients and primary care providers about options. It was also expressed that brokers were important to engage, so that they could, in turn, educate employer groups and health care providers.

There was a general lack of awareness about the option to cost share with the state. Only 2 of the 6 health plan providers we interviewed engaged in cost sharing for state quitline services. All but 1 health plan referred clients to the state quitline, and they noted that they did so because those services were evidence-based and free. They did not see any reason for paying a fee to use the state quitline services.

Insurance Brokers

Brokers who were interviewed had varying levels of knowledge regarding the ACA. According to the brokers, employers defined their cessation coverage, but it varied by whether many employees were smokers (i.e., varied by the type of employees; blue collar employees were mentioned specifically). Broker representatives perceived a difference among types of employers, and those with a small number of tobacco users only wanted what was required and participation-based, whereas those with a larger number of users were more interested in bringing down the costs that were associated with their employees being tobacco users; thus, they more interested in outcomes-based services. However, services offered depended on the broker; some brokers were more forthcoming in the information they offered regarding cessation benefits, some only offered options if an employer asked about cessation services.

The 2 brokers aware of the state quitline indicated they referred to state quitlines because services were free. The idea of cost sharing was not even a consideration. One broker expressed that if the state did not offer quitline services for free, they would have to look around for other options to recommend.

DISCUSSION

The results of this exploratory study suggested several preliminary implications to consider for state quitlines and the requirement of the ACA to include tobacco cessations as an essential health benefit. The main implications were the factors that affected the transition to cost-sharing models and the various stakeholder groups to engage.

Factors That Affected the Transition to Cost Sharing

If quitlines are to transition to a cost-sharing model, leadership will be needed from the

health departments, but this leadership is only possible if health department leadership has the autonomy to develop strategies for responding to the requirements of ACA. A clearly articulated vision about what the state quitline will provide to whom and for how long may be necessary for getting the service provider and important stakeholders (health plans, brokers, and employers) on board with any cost-sharing discussions. Service providers have a role to play in developing state strategies because they are a knowledgeable go-between group with a better understanding of the different perspectives and incentives of health plans, brokers, and employers. Therefore, service providers may be important in guiding state health departments in how to develop and implement strategies that will succeed in getting buy-ins from the various private sector players and meeting their expectations. However, the service providers are ultimately dependent on state health departments for the strategies that will be pursued.

There are several challenges state health departments will have to confront to succeed in efforts to achieve cost sharing. Although health departments may have an important proactive role to play in using ACA as an opportunity to improve how tobacco is being addressed and in making the funding for state quitlines more sustainable, being able to do so depends on how supportive political leadership is and having the resources to put toward any such initiatives. There is also a general perception by health plans and brokers that state quitlines should be free and that the state quitlines may not provide the level of data reporting and services that health plans expect from vendors, which could present major challenges for state quitlines in their efforts to arrange cost-sharing agreements.

The Various Stakeholders to Engage

As is the case for almost any health care issue, there are numerous stakeholders involved in any efforts to succeed in implementing tobacco cessation cost-sharing models. It is therefore important that efforts are made to educate and engage these various stakeholders. First, it was quite clear from the interviews that Medicaid and health care providers and systems are essential stakeholder groups to engage. Engaging health plans is necessary, but employers are also important to engage for self-insured plans. Brokers are significant as well because of the role they play in educating employers and making sure the benefits they want are included in their plans; however, the knowledge of these brokers varies a great deal. Broker associations could provide important avenues for educating brokers, and in turn, educating employers. Brokers and employers are also important stakeholders to educate to pressure carriers to include the benefits they want. In addition, if these stakeholder groups are not educated about the effectiveness of different services, they may pressure carriers to include benefits that are cheap and meet the requirements, but are not necessarily effective. Those groups that are set to benefit most from the ACA may not reap that benefit if they lack the prerequisite understanding of what their choices are.[15]

Study Limitations

There were several limitations to this exploratory study that prevented definitive implications.

Although we compared 4 states, these 4 states were too few to represent all US states. The perspectives also represented 1 point in time during a very dynamic time for health care in the United States. Finally, the individuals interviewed were not necessarily representative of the stakeholder group they were asked to represent, especially so for the health plans and brokers. In addition, Medicaid and health providers and systems are important stakeholders to include as well. For all of these reasons, the findings and implications suggested in this study should be examined further.

Conclusions

Even with these limitations, this study did increase our understanding of the complexity involved in the implementation of the ACA, specifically with regard to the requirement to include tobacco cessation as a preventive service, but also with regard to what challenges ACA might pose for state quitlines, as well as other publicly provided prevention services. Decreasing tobacco use at the population level is arguably dependent on system integration, including expanding coverage and adequate funding for the use and promotion of state quitlines,[16,17] so understanding how the ACA will affect state quitlines and their funding is important. Because states have been offering evidence-based quitline services for more than a decade now, there is the opportunity for cost sharing between the state and private insurance providers. However, there is also the danger of competition between the 2 that erodes the quality of the cessation services being offered or the state subsidizing cessation services for private providers.[18] Competition could decrease the number of referrals to state quitlines, which could jeopardize funding support, but a substantial increase in referrals to state quitlines without additional funding support could strain state quitline budgets. Preserving evidence-based state quitline services might be important for ensuring that high quality cessation services are being offered. However, there are substantial costs necessary to providing these services, and the notion that these are free could have serious implications on state and quitline budgets. The results of this study speak to the multiple stakeholders that need to be informed and engaged in cost-sharing initiatives, as well as the challenges that will need to be overcome for cost-sharing initiatives to be successful.

Most importantly, this study raised some specific questions that future studies will need to address as implementation of the ACA progresses. With the greater demand of cessation services because of ACA, who will be served by state quitline services and who will pay for those services? Which states will be successful in initiating and sustaining cost-sharing agreements with private providers and why? What effect will the ACA requirement have on the costs, quality, and access of tobacco cessation services over time? It will be important to examine these and other questions in the future to strengthen quitlines and their sustainability, as well as to guide efforts made by both the public and private sectors to fulfill the requirements of ACA. ■

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Contributors

R. H. Lemaire assisted with the study design, led data analysis, and led the writing. L. Bailey assisted with the study design, led data collection, assisted with the data analysis, and contributed to the writing. S. J. Leischow supervised the study, assisted with the study design, and contributed to the writing.

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Human Participant Protection

The Mayo Clinic institutional review board provided human participant approval for this study.

References

1. US Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General.* Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014.

2. Section 1. Preventive services recommended by the USPSTF: guide to clinical preventive services, 2014. Rockville, MD. Agency for Healthcare Research and Quality; 2014. Available at: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/section1.html. Accessed September 3, 2015.

3. Leischow SJ, Provan K, Beagles J, et al. Mapping tobacco quitlines in North America: signaling pathways to improve treatment. *Am J Public Health.* 2012;102(11):2123–2128.

4. Lichtenstein E, Zhu SH, Tedeschi GJ. Smoking cessation quitlines: an underrecognized intervention success story. *Am Psychol.* 2010;65(4):252–261.

5. Fiore M, Jaén C, Baker T, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Rockville, MD: US Department of Health and Human Services, Public Health Service; 2008.

6. Stead LF, Perera R, Lancaster T. A systematic review of interventions for smokers who contact quitlines. *Tob Control.* 2007;16(suppl 1):i3–i8.

7. North American Quitline Consortium. Results from the 2013 NAQC Annual Survey of Quitlines. Phoenix, AZ: North American Quitline Consortium; 2013. Available at: http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/Research/FINALNAQCFY13.pptx.pdf. Accessed September 4, 2015.

8. North American Quitline Consortium. Results from the 2012 NAQC Annual Survey of Quitlines. Phoenix, AZ: North American Quitline Consortium; 2012. Available at: http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/2012_annual_survey/oct23naqc_2012_final_report_.pdf. Accessed September 4, 2015.

9. Buck JA. The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Aff (Millwood).* 2011;30(8):1402–1410.

10. Yin RK. *Case Study Research: Design and Methods.* Thousand Oaks, CA: Sage; 2003.

11. Ragin CC. *The Comparative Method.* Berkeley, CA: University of California Press; 1987.

12. Kaiser Family Foundation. State marketplace statistics, April 2014. Table. Available at: http://kff.org/health-reform/state-indicator/state-marketplace-statistics-2. Accessed September 4, 2015.

13. Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2013.

14. American Lung Association. Tobacco cessation coverage 2012: helping smokers quit. 2012. Available at: http://www.lung.org/assets/documents/publications/smoking-cessation/helping-smokers-quit-2012.pdf. Accessed September 4, 2015.

15. Hall KS, Fendrick AM, Zochowski M, Dalton VK. Women's health and the Affordable Care Act: high hopes versus harsh realities? *Am J Public Health.* 2014;104(8):e10–e13.

16. Abrams DB, Graham AL, Levy DT, et al. Boosting population quits through evidence-based cessation treatment and policy. *Am J Prev Med.* 2010;38(3):S351–S363.

17. Saul JE, Bonito JA, Provan K, Ruppel E, Leischow SJ. Implementation of tobacco cessation quitline practices in the United States and Canada. *Am J Public Health.* 2014;104:e98–e105.

18. Kolstad JT, Kowalski AE. The impact of health care reform on hospital and preventive care: evidence from Massachusetts. *J Public Econ.* 2012;96(11–12):909–929.