National Health Insurance Reform:
Medicaid Coverage to Help Pregnant Women Stop Smoking

September 2010

The federal Patient Protection and Affordable Care Act (“health insurance reform”), requires state Medicaid programs to cover comprehensive tobacco cessation services for pregnant women, effective October 1, 2010. This is good news for pregnant women in Connecticut’s HUSKY Program. To date, Connecticut has been one of the few states in the nation that did not cover counseling or medications to help smokers in its Medicaid program quit. This new benefit will go a long way toward improving maternal health, birth outcomes, and health in early childhood.

Effects of Smoking on Reproductive and Infant Health

In 2004, the Surgeon General of the United States summarized the effects of smoking on health, including health before, during and after pregnancy. In addition to increased risk for cancer, respiratory, cardiovascular and other diseases, women who smoke are at increased risk of infertility. During pregnancy, women who smoke are at risk for serious and life-threatening complications, such as placenta previa (implantation in the lower uterus) placental abruption (premature separation of the placenta, accompanied by hemorrhage), premature rupture of the membranes, and preeclampsia (high blood pressure and other circulatory abnormalities; may lead to seizures). Babies born to mothers who smoke are at increased risk for stillbirth, preterm birth, low birthweight, and infant death. Nicotine is present in the breast milk of nursing mothers who smoke. Babies whose mothers smoked during pregnancy and after giving birth are up to three times more likely to die from sudden infant death syndrome as babies born to non-smokers. Exposure to secondhand smoke increases risk for respiratory tract infections and ear infections in young children.

Prevalence of Smoking During Pregnancy

Over the past decade, the prevalence of smoking among adult women in Connecticut declined from 19.4 percent in 2000 to 14.7 percent in 2009. In 2005, the most recent year for which national survey data are available, 22.5 percent of women who had recently given birth reported having smoked before, during or after pregnancy. Smokers were more likely to be young, non-Hispanic white, unmarried, less educated, low income, and enrolled in Medicaid. Fourteen percent smoked during pregnancy, based on birth certificate data or survey responses, down significantly from smoking prevalence in 2000. Site-specific smoking rates ranged from as low as five percent (New York City) to as high as 36 percent (West Virginia). On average, 46 percent of mothers quit smoking during pregnancy; about half of them relapsed after pregnancy. In a similar survey conducted in Connecticut in 2003, over 24 percent of mothers reported having smoked on an average day during the last 3 months of pregnancy and those smoking rates were highest for White and Hispanic mothers.

Birth data for Connecticut show that in 2008, 5.1 percent of babies were born to mothers who smoked during pregnancy. The rate varied by race/ethnicity from 5.8 percent of babies born to white mothers to 4.2 percent of babies born to black mothers, and 4.2 percent of babies born to Hispanic mothers. As in previous years, it is likely that the smoking rate for mothers with Medicaid coverage is considerably higher than the rate for other mothers. In 2007, 12.6 percent of babies born to mothers with HUSKY A or B coverage were exposed to tobacco in utero, compared with just 2.2 percent of babies born to other mothers.
Treatment for Tobacco Dependence

Healthy People 2010 is a statement of the nation’s goals and objectives for improving health and health care for all people. The objectives include increasing smoking cessation during pregnancy and reducing the proportion of children who are regularly exposed to tobacco smoke at home. In recognition of the fact that cost of treatment can be a barrier to quitting, the objectives include covering treatment for tobacco dependence by all Medicaid programs.

Recommended treatment entails use of one or more of the following medications: nicotine replacement (gum, patch, nasal spray, inhaler or lozenge), varenicline (Chantix, a drug that blocks nicotine uptake in the brain), and bupropion (Zyban or generic, an antidepressant medication). Counseling (group or individual) is an effective adjunct to medication.

Data from a 2009 survey of Medicaid programs suggest that while coverage of effective treatment varies by state, most programs (46 of 51 states and the District of Columbia) covered at least one type of treatment in 2009. Five states did not cover treatment for tobacco dependence in 2009 (Alabama, Georgia, Missouri, Tennessee—and Connecticut). Among those states that cover treatment, six provide comprehensive coverage of all seven medications approved by the US Food and Drug Administration (FDA), plus group and individual counseling (Indiana, Massachusetts, Minnesota, Nevada, Oregon, and Pennsylvania). Fifteen other states more covered most treatment modalities, with counseling most often the exception. In states with managed care, coverage varied by health plan if treatment was not required in the state’s contracts with the managed care organizations. Other barriers to obtaining treatment include imposition of copayments for medication or counseling, arbitrary limits on the length of treatment, annual or lifetime dollar limits, and requirements such as prior authorization, failure at one level of treatment before qualifying for another, and counseling only for those on medication. A few states covered pregnant women only.

Treatment for Pregnant Women in Connecticut’s Medicaid Program

Beginning October 1, 2010, the new health insurance reform law requires Connecticut and all other states to cover counseling and medications for smoking cessation for pregnant women in their Medicaid programs. The services must include counseling and coverage of prescription and non-prescription FDA-approved tobacco cessation agents, in accordance with US Public Health Service guidelines. This new benefit should be widely promoted to pregnant women and providers. Policy makers and health advocates should monitor implementation to ensure that the benefit is provided without cost-sharing, without limits on medications or services, and without administrative barriers like prior authorization or stepped therapy. Further, effect of this new benefit on maternal health and birth outcomes in Connecticut should be evaluated and results reported to the Department of Public Health and the Connecticut General Assembly’s Medicaid oversight councils.

Acknowledgements

Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on issues that affect child and family welfare, including tax and budget, health, juvenile justice, early childhood education, K-12 education, and foster care. This brief was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow at Connecticut Voices. The Connecticut Health Foundation provides funding for HUSKY Program policy analysis.

References

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