State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage — United States, 2016

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In 2015, 27.8% of adult Medicaid enrollees were current cigarette smokers, compared with 11.1% of adults with private health insurance, placing Medicaid enrollees at increased risk for smoking-related disease and death (*1*). In addition, smoking-related diseases are a major contributor to Medicaid costs, accounting for about 15% (>$39 billion) of annual Medicaid spending during 2006–2010 (*2*). Individual, group, and telephone counseling and seven Food and Drug Administration (FDA)–approved medications are effective treatments for helping tobacco users quit (*3*). Insurance coverage for tobacco cessation treatments is associated with increased quit attempts, use of cessation treatments, and successful smoking cessation (*3*); this coverage has the potential to reduce Medicaid costs (*4*). However, barriers such as requiring copayments and prior authorization for treatment can impede access to cessation treatments (*3*,*5*). As of July 1, 2016, 32 states (including the District of Columbia) have expanded Medicaid eligibility through the Patient Protection and Affordable Care Act (ACA),*,† which has increased access to health care services, including cessation treatments (*5*). CDC used data from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES) and the Behavioral Risk Factor Surveillance System (BRFSS) to estimate the number of adult smokers enrolled in Medicaid expansion coverage. To assess cessation coverage among Medicaid expansion enrollees, the American Lung Association collected data on coverage of, and barriers to accessing, evidence-based cessation treatments. As of December 2015, approximately 2.3 million adult smokers were newly enrolled in Medicaid because of Medicaid expansion. As of July 1, 2016, all 32 states that have expanded Medicaid eligibility under ACA covered some cessation treatments for all Medicaid expansion enrollees, with nine states covering all nine cessation treatments for all Medicaid expansion enrollees. All 32 states imposed one or more barriers on at least one cessation treatment for at least some enrollees. Providing barrier-free access to cessation treatments and promoting their use can increase use of these treatments and reduce smoking and smoking-related disease, death, and health care costs among Medicaid enrollees (*4*,*6*–*8*).

A *Healthy People 2020* objective (TU-8) calls for all state Medicaid programs to adopt comprehensive coverage of smoking cessation treatments.§ A previous study reported on state Medicaid coverage of cessation treatments during 2014–2015 in the population traditionally eligible for Medicaid coverage (*9*), but cessation coverage has not been reported among the population newly eligible for Medicaid expansion coverage in the 32 states (including the District of Columbia) that expanded Medicaid eligibility through ACA as of July 1, 2016. These states elected to expand coverage to a new eligibility group of adults aged <65 years known as the Medicaid expansion population (also known as the VIII group).

To estimate the number of adult cigarette smokers enrolled in Medicaid expansion coverage, 2014 BRFSS¶ estimates of state-specific smoking prevalence among self-reported Medicaid enrollees were multiplied by MBES** enrollment data for December 2015. Newly eligible Medicaid enrollees were defined as persons who were newly enrolled in Medicaid because of ACA Medicaid expansion. Some states expanded Medicaid eligibility to varying extents before ACA was enacted. The overall Medicaid expansion population estimates (Table 1) include persons who enrolled in Medicaid because of these previous state expansion actions, as well as persons who enrolled in Medicaid because of state Medicaid expansions under ACA. The newly eligible Medicaid population estimates include the latter group only.

* http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision.

† Coverage for the adult expansion population must be offered through an alternative benefit plan. States generally have expanded coverage in one of two ways: by extending traditional Medicaid coverage to the Medicaid expansion population or by creating a benefit package that is not aligned with the state's traditional Medicaid state plan and using managed care for the expansion population. States can also provide subsidies to this population that are used to purchase coverage offered in the state or federally facilitated marketplace created by the Patient Protection and Affordable Care Act.

§ https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use/objectives.

¶ Data were obtained from the Behavioral Risk Factor Surveillance System (BRFSS) 2014 health care access module (http://www.cdc.gov/brfss/). Smoking prevalence estimates were calculated for 2014 BRFSS respondents aged 18–64 years who reported the following: 1) smoking ≥100 cigarettes during their lifetimes and smoking every day or some days at the time of the interview, and 2) having Medicaid or another state program as the primary source of their health care coverage. The relevant BRFSS question did not distinguish between traditional and expansion Medicaid coverage.

** https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes.html and http://kff.org/medicaid/issue-brief/an-overview-of-new-cms-data-on-the-number-of-adults-enrolled-in-the-aca-medicaid-expansion/.

To assess cessation coverage available to the state Medicaid expansion population as of July 1, 2016, the American Lung Association collected data on coverage of, and barriers to accessing, all evidence-based cessation treatments except telephone counseling[††] (a total of nine treatments) for state Medicaid expansion populations. The American Lung Association compiled data from Medicaid member websites and handbooks; Medicaid provider websites and handbooks; policy manuals; plan formularies and preferred drug lists; Medicaid state plan amendments; and relevant regulations and legislation. Personnel from state Medicaid agencies and health departments or other state government agencies were consulted to confirm the accuracy of collected information, retrieve missing documents, and reconcile discrepancies. Data were collected during July 19–August 18, 2016.

As of December 2015, approximately 3.3 million adult cigarette smokers were enrolled in Medicaid expansion coverage, including approximately 2.3 million adults who were newly eligible for Medicaid expansion coverage (Table 1). The number of adult smokers enrolled in Medicaid expansion coverage ranged from 2,567 in Alaska to 618,395 in New York; the number of newly eligible adult smokers enrolled in this coverage ranged from 2,567 in Alaska to 291,351 in Pennsylvania (Table 1).

As of July 1, 2016, nine of the 32 states that have expanded Medicaid eligibility (Colorado, Connecticut, Indiana, Massachusetts, Minnesota, North Dakota, Ohio, Pennsylvania, and Vermont) covered all nine cessation treatments for all Medicaid expansion enrollees (Table 2). Of the 32 states, 17 states covered individual counseling for all Medicaid expansion enrollees, 11 covered group counseling for all enrollees, and 19 covered all seven FDA-approved cessation medications for all enrollees. All 32 states imposed at least one barrier (e.g., copayments or prior authorization) on at least one treatment for at least some enrollees (Table 3). Six states required copayments for at least one cessation treatment for all enrollees, with an additional seven states requiring copayments for some enrollees. Twelve states required prior authorization to obtain at least one cessation treatment for all enrollees, with an additional 14 states requiring prior authorization for some enrollees.

[††] Telephone cessation counseling is available free to callers to state quitlines (including Medicaid enrollees) in all 50 states and the District of Columbia through the national quitline portal 1-800-QUIT-NOW, and therefore is not included in this report. In June 2011, the Centers for Medicare & Medicaid Services (CMS) announced that it would offer a 50% federal administrative match to state Medicaid programs for the cost of state quitline counseling provided to Medicaid enrollees. Although not discussed in this report, some state Medicaid programs cover or otherwise provide access to telephone counseling for at least some Medicaid enrollees.

Summary

What is already known about this topic?

Medicaid enrollees smoke cigarettes at a higher rate than do privately insured U.S. residents. States that expand Medicaid eligibility are able to extend coverage to large numbers of adult smokers who are not eligible for traditional Medicaid cessation coverage, thereby substantially increasing the potential impact of Medicaid cessation coverage.

What is added by this report?

By expanding Medicaid eligibility under the Affordable Care Act, 32 states have extended Medicaid cessation coverage to about 2.3 million adult smokers who were not previously eligible for Medicaid. All 32 of these states covered some cessation treatments for all Medicaid expansion enrollees. Nine states covered all nine cessation treatments considered in this study for all Medicaid expansion enrollees, and 19 states covered all seven FDA-approved cessation medications for all enrollees. All 32 states imposed one or more barriers to accessing at least one cessation treatment for at least some enrollees.

What are the implications for public health practices?

States that have expanded Medicaid can take further steps to help smokers quit by covering proven cessation treatments more fully, removing barriers to accessing covered treatments, making Medicaid enrollees and their health care providers aware of these treatments, and monitoring use of these treatments.

Discussion

Under the Medicaid expansion provision of ACA, states can expand Medicaid eligibility to include adults aged <65 years with incomes ≤138% of the Federal Poverty Level.[§§,¶¶] As of July 1, 2016, 32 states have expanded Medicaid eligibility, a step which has made Medicaid cessation coverage available to approximately 2.3 million adult smokers who were not previously eligible for Medicaid. Moreover, all of these states covered some cessation treatments for all Medicaid expansion enrollees, and 19 states covered all seven FDA-approved cessation medications for all enrollees. However, only nine states covered all nine cessation treatments, and all 32 states imposed one or more barriers to accessing cessation treatments for at least some enrollees. Several states, including Michigan and Minnesota, have made notable progress in removing barriers to cessation coverage for both their expansion and traditional (i.e., nonexpansion) Medicaid populations in recent years. Other states have made more recent progress in this regard. For example, Maryland removed copayments for cessation

[§§] http://housedocs.house.gov/energycommerce/ppacacon.pdf.

[¶¶] Although a June 2012 Supreme Court ruling held that a state cannot lose federal funding for its existing Medicaid program if it does not participate in the expansion, financial incentives exist for all states to expand eligibility for Medicaid coverage (National Federation of Independent Business, et al. v. Kathleen Sebelius, Secretary of Health and Human Services, et al.; 132 S. Ct. 2566 [2012]).

TABLE 1. Estimated number of current smokers aged 18–64 years in Medicaid Expansion—32 states,* December 2015

State	Adults enrolled in Medicaid				Adult smokers in Medicaid expansion	
	Total no.†	No. in Medicaid expansion†	No. newly eligible in Medicaid expansion†,§	Medicaid smoking prevalence¶	Total no.**	No. newly eligible**
Alaska	**124,883**	8,500	8,500	30.2	**2,567**	2,567
Arizona	**1,873,397**	412,957	105,711	30.4	**125,622**	32,157
Arkansas	**919,768**	291,602	266,741	NA	**NA**	NA
California	**NA**	NA	NA	NA	**NA**	NA
Colorado	**NA**	NA	NA	27.4	**NA**	NA
Connecticut	**840,619**	200,988	186,967	37.0	**74,426**	69,234
Delaware	**210,636**	60,006	9,280	37.4	**22,460**	3,474
District of Columbia	**243,612**	61,946	61,946	40.7	**25,224**	25,224
Hawaii	**313,126**	107,485	33,427	NA	**NA**	NA
Illinois	**2,869,749**	641,439	616,265	35.8	**229,892**	220,869
Indiana	**1,244,321**	361,687	222,364	48.3	**174,550**	107,313
Iowa	**585,978**	146,310	135,963	43.4	**63,499**	59,008
Kentucky	**1,274,166**	439,044	439,044	50.1	**219,785**	219,785
Louisiana	**1,444,601**	NA	NA	35.9	**NA**	NA
Maryland	**1,061,749**	231,484	231,484	30.3	**70,140**	70,140
Massachusetts	**1,805,041**	384,390	0	32.8	**126,157**	0
Michigan	**2,287,620**	613,761	579,378	40.9	**250,844**	236,792
Minnesota	**1,186,498**	208,492	207,683	32.6	**68,031**	67,767
Montana	**138,970**	NA	NA	51.3	**NA**	NA
Nevada	**NA**	NA	NA	35.6	**NA**	NA
New Hampshire	**187,999**	49,040	48,759	48.8	**23,946**	23,809
New Jersey	**NA**	NA	NA	23.0	**NA**	NA
New Mexico	**840,108**	235,425	235,425	30.4	**71,522**	71,522
New York	**5,768,918**	2,276,859	285,564	27.2	**618,395**	77,559
North Dakota	**NA**	NA	NA	43.8	**NA**	NA
Ohio	**2,930,308**	653,434	607,139	47.4	**309,466**	287,541
Oregon	**1,055,080**	518,904	452,269	35.8	**185,768**	161,912
Pennsylvania	**2,670,350**	603,335	547,962	53.2	**320,793**	291,351
Rhode Island	**279,851**	59,280	59,280	29.8	**17,671**	17,671
Vermont	**207,146**	60,678	0	36.8	**22,323**	0
Washington	**1,813,800**	592,114	577,422	34.2	**202,562**	197,536
West Virginia	**554,210**	174,999	174,999	48.9	**85,627**	85,627
Total	**34,732,504**	**9,394,159**	**6,093,572**	**NR**	**3,311,270**	**2,328,858**

Abbreviations: NA = not available; NR = not reported.

* Includes the District of Columbia.

† Enrollment estimates were drawn from the Centers for Medicare and Medicaid Services Medicaid Budget and Expenditure System (MBES) CMS 64 Total Medicaid Enrollees - VIII Group Break Out Report, October–December 2015, Updated June 2016 (https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-oct-dec-2015.pdf). MBES was missing information for seven expansion states for the period in question.

§ The total VIII group category includes persons who enrolled in Medicaid because of actions in some states that expanded Medicaid eligibility before enactment of the Patient Protection and Affordable Care Act (ACA) and persons who enrolled in Medicaid because of state Medicaid expansions under ACA. The total VIII group newly eligible category only includes the latter group.

¶ Data were obtained from the Behavioral Risk Factor Surveillance System (BRFSS) 2014 health care access module (http://www.cdc.gov/brfss/). Smoking prevalence estimates were calculated for 2014 BRFSS respondents aged 18–64 years who reported: 1) smoking ≥100 cigarettes during their lifetimes and smoking every day or some days at the time of the interview, and 2) having Medicaid or another state program as the primary source of their health care coverage. The relevant BRFSS question did not distinguish between traditional and expansion Medicaid coverage.

** BRFSS smoking prevalence estimates from 2014 were applied to December 2015 enrollment data to generate estimates of smokers with expansion Medicaid coverage. Although one decimal point prevalence estimates are reported here, two decimal point prevalence estimates were used in calculating the total and newly eligible numbers of smokers in the VIII group.

medications for enrollees in both expansion and traditional Medicaid, effective October 21, 2016. In September 2016, California enacted legislation requiring the state Medicaid program to cover a comprehensive cessation benefit for both the expansion and traditional Medicaid populations, effective January 1, 2017. Providing and promoting evidence-based cessation coverage has been found to be a cost-effective way to help smokers quit. Among the Medicaid population in Massachusetts, an evidence-based, heavily promoted Medicaid cessation benefit was associated with a reduction in smoking prevalence, from 38.3% to 28.3% over a 3-year period (*7*). For each dollar spent on the benefit over a 3-year period, an estimated $3.12 in medical savings occurred from averted cardiovascular hospitalizations alone (*4*).

With regard to tobacco cessation coverage, Medicaid expansion coverage is subject to different ACA provisions than

TABLE 2. Medicaid expansion coverage of tobacco cessation treatments — 32 states,* July 1, 2016

State	Treatment								
	Individual counseling	Group counseling	Nicotine patch	Nicotine gum	Nicotine lozenge	Nicotine nasal spray	Nicotine inhaler	Bupropion	Varenicline
Alaska	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arizona	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arkansas	V	No	V	V	V	V	V	Yes	Yes
California	V	V	Yes	Yes	Yes	V	V	Yes	Yes
Colorado	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Delaware	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
District of Columbia	NA	NA	Yes	Yes	Yes	V	V	Yes	Yes
Hawaii	Yes	V	Yes	Yes	V	V	V	Yes	Yes
Illinois	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Indiana	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	V	V	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kentucky	V	V	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Louisiana	No	V	V	V	V	Yes	Yes	Yes	Yes
Maryland	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	V	V	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Minnesota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Montana	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nevada	No	V	V	V	V	Yes	Yes	Yes	Yes
New Hampshire	V	No	V	V	V	Yes	Yes	Yes	Yes
New Jersey	V	V	Yes	V	Yes	V	V	Yes	Yes
New Mexico	V	V	Yes	Yes	Yes	V	V	Yes	Yes
New York	Yes	Yes	Yes	Yes	V	V	V	Yes	V
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oregon	V	V	Yes	Yes	V	V	V	Yes	Yes
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rhode Island	Yes	Yes	Yes	Yes	Yes	V	V	Yes	Yes
Vermont	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Washington	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
West Virginia	No	No	Yes	Yes	V	V	V	Yes	V
Totals									
Yes	**17**	**11**	**28**	**27**	**24**	**22**	**22**	**32**	**30**
No	**5**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
V	**9**	**10**	**4**	**5**	**8**	**10**	**10**	**0**	**2**
NA	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Abbreviations: NA = not available; V = varies by plan.
* Includes the District of Columbia.

traditional Medicaid coverage (*5*). Unlike traditional Medicaid coverage, Medicaid expansion coverage is subject to Section 1001 of ACA, which requires coverage without cost-sharing of preventive services receiving an A or B rating from the U.S. Preventive Services Task Force (USPSTF) (*5*). Tobacco cessation intervention has received an A-grade from USPSTF.***,†††

Guidance issued by the departments of Health and Human Services, Labor, and Treasury in May 2014 defines how this provision applies to cessation coverage.§§§ To assist with compliance with Section 1001, CMS is contacting states to ensure that they understand the previous guidance and to provide technical assistance for states to achieve compliance. Several states that currently require copayments for some cessation treatments for Medicaid expansion enrollees have indicated that they are planning to remove this requirement.

More comprehensive state Medicaid coverage of cessation treatments is associated with increased use of cessation medications and increased quit rates among smokers enrolled in Medicaid (*6*,*8*). Moreover, removing barriers such as

*** https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1.

††† The federal prohibition on cost-sharing for tobacco cessation services for the Medicaid expansion population in the new eligibility group for adults was explained in CMS guidance issued to state Medicaid agencies in 2012 (https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf). CMS also issued an Information Bulletin in January 2016 on changes in Essential Health Benefit standards affecting Medicaid Alternative Benefit Plans, which reiterates the cost-sharing prohibition (https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf).

§§§ https://www.dol.gov/ebsa/faqs/faq-aca19.html.

TABLE 3. Barriers to Medicaid expansion coverage of tobacco cessation treatments — 32 states,* July 1, 2016†

State	Copayments required	Prior authorization required	Counseling required for medications	Stepped-care therapy§	Limits on duration	Annual limits on quit attempts	Lifetime limits on quit attempts
Alaska	Yes	Yes	No	No	Yes	Yes	No
Arizona	No	No	No	No	Yes	Yes	No
Arkansas	V	V	No	No	V	V	No
California	No	V	No	V	V	V	No
Colorado	V	V	V	No	Yes	Yes	No
Connecticut	No	Yes	No	No	No	Yes	No
Delaware	Yes	Yes	Yes	Yes	Yes	Yes	No
District of Columbia	No	V	No	No	V	V	No
Hawaii	No	V	V	V	V	Yes	No
Illinois	Yes	No	No	No	No	No	No
Indiana	No	Yes	V	V	Yes	Yes	No
Iowa	No	Yes	Yes	Yes	Yes	Yes	No
Kentucky	No	Yes	No	V	Yes	Yes	No
Louisiana	V	V	V	V	V	V	No
Maryland	NA	Yes	No	Yes	No	Yes	No
Massachusetts	Yes	Yes	No	No	No	Yes	No
Michigan	No	No	No	No	V	No	No
Minnesota	No	NA	No	No	V	No	No
Montana	No	Yes	No	NA	NA	NA	No
Nevada	No	Yes	No	V	Yes	Yes	No
New Hampshire	V	No	No	No	V	V	No
New Jersey	No	V	No	V	No	V	V
New Mexico	No	V	V	No	V	V	No
New York	Yes	V	No	V	Yes	Yes	No
North Dakota	No	No	No	No	Yes	Yes	No
Ohio	V	V	No	V	V	V	No
Oregon	No	V	V	V	V	V	No
Pennsylvania	V	V	No	No	Yes	Yes	No
Rhode Island	No	Yes	V	V	Yes	Yes	No
Vermont	Yes	Yes	No	Yes	Yes	Yes	No
Washington	No	V	V	V	Yes	Yes	No
West Virginia	V	V	V	No	V	V	No
Totals							
Yes	**6**	**12**	**2**	**4**	**14**	**18**	**0**
No	**18**	**5**	**21**	**15**	**5**	**3**	**31**
V	**7**	**14**	**9**	**12**	**12**	**10**	**1**
NA	**1**	**1**	**0**	**1**	**1**	**1**	**0**

Abbreviations: NA = not available; V = varies by plan.
* Includes the District of Columbia.
† Barriers apply to one or more cessation treatments.
§ Refers to a requirement that a person try and fail to quit with one cessation medication before being able to access another cessation medication.

copayments, which pose a financial obstacle, and prior authorization, which can delay accessing services unless a process is in place to expedite authorization, further increases access to these treatments (*3*,*5*). Communicating to smokers and health care providers that cessation treatments are covered is also important to ensure that they are aware of and use covered treatments (*5*,*7*). A recent study found that only approximately 10% of Medicaid enrollees who smoked received a prescription for a tobacco cessation medication in 2013, with wide variation in use of cessation medications across states (*10*). Medicaid cessation coverage has the greatest effect when it is available to large numbers of smokers and is widely used (*5*,*7*).

The findings in this report are subject to at least four limitations. First, enrollment estimates were drawn from a new CMS reporting system whose primary purpose is to allow states to claim the enhanced Medicaid expansion federal matching rate; this system was missing information for seven expansion states for the assessment period. Second, the state smoking prevalence estimates were based on respondents who reported that they smoked and were enrolled in Medicaid; these estimates were not available for three states, and the relevant BRFSS question did not distinguish between traditional and Medicaid expansion coverage. In addition, 2014 smoking prevalence estimates were applied to December 2015 enrollment data to generate estimates of smokers enrolled in Medicaid expansion. Third, in cases where official coverage documents were not publicly available, were outdated, or conflicted with one another, state government personnel were consulted to provide additional

documentation or resolve discrepancies; this information might be inaccurate in some cases. Finally, cessation coverage can vary widely across Medicaid expansion managed care plans, making it challenging to determine coverage.

The 32 states that have expanded Medicaid eligibility under ACA are providing Medicaid cessation coverage to approximately 2.3 million adult smokers who were not previously eligible for Medicaid. These states can take further steps toward helping these smokers quit by more fully covering cessation treatments, removing barriers to accessing covered treatments, making Medicaid enrollees and providers aware of these treatments, and monitoring use of these treatments (*3*,*5*–*7*). State Medicaid programs that take these actions can substantially reduce tobacco use and tobacco-related disease and health care costs among a vulnerable population (*4*–*7*). Opportunities exist for the 19 states that have not expanded Medicaid eligibility to reduce smoking among low-income adults by making their cessation coverage more broadly available. Providing barrier-free access to cessation treatments and promoting their use are important components of a comprehensive approach to reducing tobacco use (*3*,*5*–*7*).

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