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**Introduction**

This assignment is concerned with the description, elaboration and documentation of a 2014 case study about a notable development in tobacco cessation—the Affordable Care Act (ACA) 2014. It will be analyzed that what are the adverse physical, mental and emotional health consequences of consuming tobacco passively, what consequences led to the development of ACA, what measures were taken by state governments before the act came into being, what are the potential implications of this act in the tobacco cessation and to what extent stakeholders want these implications to be implemented. The literature under contemplation was a qualitative study having interviews as data collection tools and subjects were selected through purposive sampling technique—increasing the element of subjectivity and threatening validity and reliability of the research. However, the information and insights gain from the selected stakeholders e.g., quitline service providers, state health departments, insurance brokers and health plans from the four US states filled the perpetuating and existing literature gap regarding ACA implementation. This article will not only contribute to the existing knowledge about ACA and cost-sharing but also help changing various misconceptions of these stakeholders associated with the state-driven tobacco cessation program—the quitline service (telephone helpline for counseling, psychotherapy, medications and available treatment options).

**According to this case study, how have the stakeholders in tobacco cessation changed since the passage of the ACA and what are the implications of these changes?**

Addiction is referred to as a chronic condition encapsulating drug-seeking in compulsive manner evident from the amount of energy, time, effort and money that person uses to consume drugs (CDC, 2014). It not only generates short term euphoric effects in addicts but is potent enough to induce long-term emotional and psychological changes in brain at molecular level. The addiction causing agent in tobacco is known as nicotine. Particular areas of brain responsible for euphoric effects (feelings of pleasure without any apparent cause) are targeted by nicotine within the seconds of smoking or chewing it. Approximately it is the matter of seconds that nicotine gets absorbed into the blood and reaches to reward system of brain—producing exceptionally happy moments.

 This point does not require further elaboration that individual is innately programmed to avoid pain and demonstrates strong affinity for pleasure seeking activities. Nicotine acts as a source of happiness for them particularly when they are passing through the tumultuous circumstances of their lives in emotional, behavioral or social contexts (CDC, 2014). Nicotine dependence welcomes a variety of organic impairments including cerebrovascular disorders, cardiovascular disorders, kidney, skin, liver and lung damage (CDC, 2016). Individuals who remain exposed to cigarette smoke also demonstrate adverse health consequences specifically infants and children are more vulnerable to smoke related conditions (CDC, 2016). Estimation indicates that second-hand cigarette smoke is inhaled by nearly 3 million children in US under the age of six (USDHHS, 2014).

**The most dreadful healthcare adversities include sudden infant death syndrome (SIDS), ear infections, respiratory problems and asthma. Moreover, cigarette smoke has the potential to induce slower lung growth in infants with elevated instances of pneumonia and bronchitis as compared to the infants with nonsmoker family members. Due to lung problems, coughing and wheezing in children is more frequently exhibited by exposed infants** (USDHHS, 2014)**.**

***“The health consequences of smoking”* is a recent report by Surgeon General—presented after 50 years of deliberate painstaking analysis and research-based contemplation—which indicated that nearly 42 million adults are currently cigarette smokers whereas associated annual mortality rates are reported to be 480,000 in the United States** (USDHHS, 2014)**. After unveiling compelling statistics, this report attempted to communicate the efficacy of preventive and management strategies putting forward the efforts made by US Preventive Services Task Force. Hence, these healthcare complications and mortality rates associated with tobacco use are equally preventable and manageable through tobacco cessation policy makings and implementations. In 2014, Patient Protection and Affordable Care Act (ACA) included tobacco cessation as the most desired healthcare outcome after US Preventive Services Task Force’s successful operation against tobacco cessation—attributing it as the most successful preventive condition in healthcare history (USPSTF, 2014).**

 **After ACA reforms, health insurance took relatively broader scope than it was before. It was termed as an essential requirement of ACA to serve healthcare insurance for covering public benefits including wellness services, preventive services and chronic disease management (Leischow et. al., 2015). ACA attributed tobacco cessation as the most required free-of-cost healthcare service for addicts starting from the year 2014. These services were meant to be provided by insurers and/or health planners. The collaborative history of state healthcare institutions, health service providers and other private organizations aimed at establishing a network of state-based quitlines throughout the United States is older than 10 years—even before Affordable Care Act (ACA) reforms. Tobacco cessation quitlines (TCQs) are referred to as telephone-based guidance programs offering informational, social and emotional support, telephone counseling and medications—aimed at fostering tobacco cessation, compliant with the predetermined standards of the US Public Health Services clinical guidelines (USPHS) (Buck, 2011). Currently, all the 50 US states are having telephonic quitlines including Districts of Guam, Columbia and Puerto Rico.**

 **Estimation indicates that during the fiscal year to 2013, the cost consumed by quitline service was approximately $1.7 million. State government was found responsible for approximately 77% fiscal support in smoking cessation program, Center of Disease Control (CDC) participated and offered 18% financial support whereas rest of the 2% support was offered by notable and relatively newer private sources and third parties—employers, health plans and Medicaid—as a result of successful cost-sharing agreements between state departments and private corporations and programs (USDHHS, 2014).**

 **As far as implementation of ACA guidelines is concerned, tobacco cessation services carry several general implications as well as specific quitline services aimed at providing free-of-cost services to the troubled individuals (USDHHS, 2014). Evidence based services through Quitline program were being provided by state departments since past ten years; need of the hour was to develop and implement private healthcare plans for mitigating addiction nuisance hence, the most striking question was the cost sharing between state departments—already providing free-services—and private organizations. Cost sharing in tobacco cessation was referred to as the act of distributing the costs of counseling and medications for the addicts between state departments and private services (either 50% or some proportion). It can take many forms—for example, 100% cost sharing encapsulates private healthcare plans to bear 100% costs of quitline services within particular states whereas 50% cost sharing encompasses equal cost bearing by private healthcare plans including expense of medicines and addiction counselors.**

 **In addition to the cost sharing, another implication of ACA guidelines is signing of contract between private healthcare planners and service providers of the state department quitline services. Both the parties could be enabled to bypass states through signing direct contracts with the quitline service providers or bypassing can take place between existing quitline together—another potential alternative to meet ACA requirement.**

**Comparing the two ACA implications, studies suggest that cost sharing is more conductive and compelling option for employers and health plans because they will have to pay less if work collaboratively with the state departments as compared to the payment that they will have to offer in case of direct contact. Another intervening factor is the willingness of state departments to pay the administrative expenses of quitline services for conjoined employers to promote quitline tobacco addicts within the state.**

**In a nutshell, keeping the adverse healthcare consequences of tobacco use in view, it was necessary for the constitutional agencies to include tobacco cessation in their preference list named Affordable Care Act (ACA). With the development of this act, tobacco cessation approach took a broader and comparatively radical direction with the involvement of private employers and healthcare plans in collaboration with the state quitline services for enhancing the number of quitline tobacco-addict users and fostering the prevention and management of tobacco addiction through education, counseling and medication. Implication of ACA in tobacco cessation can be demonstrated through cost sharing and contracting between state departments and private employers/ organizations. However, cost sharing was found to be more favorable option for the employers to share their services with state quitline program in terms of business benefits.**

**Analyze the efficacy of the various states’ collaboration between stakeholders. (Leadership)**

The selected study (Robin, et. al., 2015) was aimed at exploring the views of various key stakeholders about the cost-sharing strategy with the state-based telephonic quitline program aimed at mitigating tobacco addiction through free counseling services, psychotherapy, education and medications to tobacco users—a new requirement of the Patient Protection and Affordable Care Act 2014 (ACA). This study used qualitative data-obtaining and analysis techniques e.g., interviews and in-depth qualitative analysis. Desired representative sample was drawn from the population using purposive sampling technique and 45-90 minute interview sessions were used for obtaining data from the selected subjects during April-May 2014. Subjects consisted of quitline service providers, state health departments, insurance brokers and health plans from the four US states (Robin et. al., 2015).

Proactive strategy was demonstrated by State 1 with the minimal support from State Departments for executing ACA guidelines. The selected representatives of state health department were exceptionally knowledgeable about the ACA guidelines concerning tobacco cessation (Robin et. al., 2015). They also demonstrated inclined preference for cost-sharing method as the best implicative strategy for ACA. State health department representatives presented an articulated vision of the their department as the centralized institution for providing a sound basis to the cost sharing agreements; their service providers were strongly prohibited to make any direct contact with the healthcare plans of states. Healthcare plans of state were also knowledgeable about the state quitline and took active participation in cost sharing. Uninsured and Medicaid tobacco users were found on top of the preference list of US healthcare department (Robin et. al., 2015).

Moving to the state 2, their informants manifested superficial knowledge about the ACA guidelines. There was found a very limited initiative by state health department in developing interactions with the private employers and organizations; only quitline service providers were asked to develop proximal interactions with private sector individuals. The broker representatives indicated a small number of employees reflecting the state’s proposition of dependence on the service providers. On the other hand, state department representatives were in view that its quitline service level and discretionary population should not be altered under the influence of ACA because there is sufficient state funding and performance in the area. The overall representatives were quite satisfied with the current quitline system; this is the reason that they are reluctant to put further efforts to ensure private healthcare plan intervention and cost-sharing (Robin et. al., 2015). However, the only movement they showed was to ask the private plans to offer free-of-cost medications to the state residents while they will continue providing counseling and therapeutic services to their clients.

Moving to the state 3, representatives were not much knowledgeable about the ACA guidelines. State healthcare department was having traditional bureaucratic framework—entirely depending upon the political leadership for strategic planning (Robin et. al., 2015). This state had fiscal funding only from CDC without any financial support from the state department, communicating absent initiative from state department to comply ACA guidelines regarding quitline services. Civil servants were given less decision-making authority under the political influence hence a very little improvement in tobacco cessation was made. Other than this, other potential reason behind their preference for quitline system was its free nature e.g., providing free services to the clients including counseling, psychotherapy and medications. Health plans were although welcomed by state departments yet no incentive was provided them for cost sharing.

The state 4, countering the above mentioned trend, was intended at performing better than rest of the states in terms of collaborative cost-sharing system, communicated by the selected representatives. Cost sharing was marked up to 50% aimed at improving systems, incentivizing costs, improvising access for leading to sustainable fiscal strategy of the quitline in future (Robin et. al., 2015). The actual strategy revolved around initiating pilot programs and providing quitline services to private organizations for the 2 year tenure during which they could observe the effectiveness and then enter cost-sharing arrangements upon satisfactory experience. The state department was only concerned with the preventive assistance of tobacco users with Medicaid, underinsured, uninsured whereas private healthcare plans were made to bear the burden of the rest. However, no guarantee was there that employers will pay for their expense for 2 years.

In a nutshell, the determination of role that state health departments intend to play under the influence of ACA requirements varies greatly from state to state. In the first two states, insurance brokers and health plans demonstrated inclined preference for state quitline because it was providing its evidence-based services since last 10 years without any disruption. On the other hand, state 3 and 4, private stakeholders manifested reluctant cost-sharing willingness. It can be concluded that efficacy of tobacco cessation system can excellently be achieved under ACA guidelines only if states bring a huge array of stakeholders together, provide them a conductive business environment and make active attempts to overcome the preoccupations about free-of-cost quitline services.

**How might the information gleaned from this case study impact operational decision making by health plan informants? (Critical Thinking) 750**

This question can better be answered through comparing the views of health plan informants within this study and then their “supposed” altered views after consulting this case study. Starting from the case study, total of 6 health plan informants were undertaken interviews. Out of them, 5 subjects were found having adequate knowledge about the Affordable Care Act requirements and entrusted internal reserves with proficiency on the ACA. They further communicated that services provided by the state departments are perfectly compliant with the ACA guidelines but intention behind putting this act forward is only concerned with the access of uninsured and underinsured tobacco users to the quitline services and with the incentive it postulates.

Moreover, it was an articulated perception of selected subjects that private healthcare stakeholders only compete for eligible and favorable employees—recognizing the needs to offer services encapsulating preventive measures to enhance their organizational commitment. Health plan informants considered themselves as primary care providers and responsible for client’s education (Robin et. al., 2015). It was also a common perception that brokers must engage themselves within field scenarios so that they could, in turn, educate and counsel private employers, stakeholders and other healthcare providers.

As far as the option of cost sharing is concerned, they were lacking awareness about it. Only two health plan providers were found to have adequate knowledge about cost sharing for the state-offered quitline services. Five health plan providers readily referred the addicts to the state quitline services just because those services were free and evidence based in nature—no reason was seen by them to pay fee for using state quitline services (Robin et. al., 2015).

Analyzing the above mentioned points, it can be assumed that a health plan provider, after consulting this piece of information will surely change his perspective about the cost sharing process. They were having adequate knowledge of ACA guidelines aimed at improving tobacco cessation for all residents, but they were completely unaware of the cost sharing option for practicing ACA instructions (Robin et. al., 2015). This article will enable them to retrospect and find a best suited option to practice ACA instructions particularly for the uninsured and underinsured tobacco users. After understanding cost sharing options, they will encourage brokers and other private healthcare employers to think with the broader rationality and attributing cost sharing as a way to implement ACA instructions appropriately. They will find their professional roles much more than just being healthcare providers and educators. On the whole, this article will help change their perspective, incorporating cost-sharing knowledge and significance in the best possible manner.

**How did each health plan informant’s communication capabilities impact the overall efficacy and sustainability of the state’s quitline? (Communication) 750**

In this study, total of 6 health plan providers were interviewed for acquiring their viewpoints about the development and implementation of strategies conductive to ACA guidelines—particularly cost-sharing. Out of them, 5 subjects were found having adequate knowledge about the Affordable Care Act requirements and entrusted internal reserves with proficiency on the ACA. They further communicated that services provided by the state departments are perfectly compliant with the ACA guidelines but intention behind putting this act forward is only concerned with the access of uninsured and underinsured tobacco users to the quitline services and with the incentive it postulates. Five health plan providers readily referred the addicts to the state quitline services just because those services were free and evidence based in nature—no reason was seen by them to pay fee for using state quitline services.

This interview demonstrates that they are overwhelmingly preoccupied with the free-of-cost and evidence based interventions of quitline, ignoring the element of diversity and dynamism in the field of tobacco cessation. In other words, these stakeholders lack complete knowledge about how other services might be effective for eradicating this perpetuating illness. They are exceptionally delusional about the benefits and cheapness of state program but are not pretty much concerned with its effectiveness in terms of its 10 year performance—which is although effective to some extent but tobacco related incidence and mortality rate is rising surpassingly.

Now the question arises, how private stakeholder can add to the development and quality maintenance of quitline? Answer is unexpectedly simple; ACA’s guidelines encouraged private stakeholders to share the burden of expenses (cost sharing) with varying proportions, as a result, a business competition between various stakeholders will surely minimize the number of referrals that health providers offer to the state quitline which, in turn, will impend the funding support to state quitline but it is much better than having a substantial number of referrals and limited funding support to address it. Hence, it will minimize the financial strain over state to address a pool of individuals requiring treatment services.

ACA put forward unique guidelines for an effective transition in this conventional state-based cessation approach by generating idea that private stakeholders must also take active participation in quitline service provision and that prerequisite understanding is quite necessary for gaining business benefits from ACA. Health plan stakeholders must have realistic knowledge about how system works; eradicating tobacco use from the population is holistically reliant on the integration of systematic bodies, involving expanding adequate financial aid and coverage for the promotion of state quitline system. Hence it is quite significant for the health plan providers to have a deep insight about the structural and functional aspects of quitline service, which directly affects its sustainability, growth and future direction. Currently, all the selected informants referred to the quitline services stimulating the idea that they need to be educated about other options as well (Robin et. al., 2015).

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