

Round Table Report from Employee Tobacco Use seminar on April 17, 2008

Group A

Moderator: John Stampen, The Alliance

The group chose to focus its efforts on how to effectively encourage people to quit using tobacco.

Highlights of the discussion included:

1) Direct monetary incentives for smoking cessation may not be sufficient to sway employees if they are the only benefit or incentive offered.

Company A reported that since 2005, it has offered a direct monetary incentive of \$1,000 for smoking cessation in the form of a health insurance premium discount. This discount represents 20% of the cost of a premium for single coverage. The discount is provided when an employee states that he or she is a non-smoker, without requiring a blood test or health risk assessment (HRA). However, if an employee who claimed non-smoking status is later found to have used tobacco, the employee loses his or her health benefits and can never re-enroll in the health plan. Roughly 35% of Company A's workforce currently uses tobacco. Company A reported that offering only a health premium discount does not appear to have had a positive impact on smoking. The company has noted, however, that several employees who smoke reported that the 2008 increase in the cigarette tax made them realize that they spent the equivalent of a car payment buying cigarettes each year, which gave them a desire to quit.

2) The average response rate of smokers to cessation benefits within the workplace is 10% per year, based on statistics gathered by the American Cancer Society "Quit Line" statistics.

Ongoing promotion of these benefits is required to boost usage.

3) Promoting smoking cessation can be affected by the nature of the workforce and the type of health plan offered.

Company B employs a highly mobile sales force in numerous locations, with as many as 80% of employees smoking at a single facility. Some employees are covered by high-deductible health plans and health savings accounts (HSAs), which add another layer of complexity to designing benefits for smoking cessation. To date, Company B has kept its smoking cessation program separate from its health plan because of these issues. Company B has gone smoke-free in its facilities, but created "smoking huts" on its campuses. The company currently reimburses employees for smoking cessation expenses, but participation is low and the company finds it difficult to figure return on investment for smoking cessation due to high turnover.

In situations where employee turnover is high, round table participants suggested examining factors that are unaffected by turnover, especially productivity and worker's compensation, to determine return on investment.

3) Policies that favor reimbursement for smoking cessation may be less effective than paying for costs up-front.

Company C pays up to \$500 for smoking cessation expenses, but employees must be smoke-free for six months to qualify. "Up front" benefits that support smoking cessation, rather than reimbursement, were one option to boost participation suggested by round table participants. The company's next steps include running a report on 2007 usage of smoking cessation benefits. Company C has a high number of smokers. Its workplace is smoke-free, including a smoke-free zone 50 feet around its buildings. Usage of smoking cessation benefits increased significantly this year and the company wants to support that trend.

4) It is difficult to gather accurate statistics about employees who smoke without an HRA.

Alternatives suggested by round table participants included voluntary employee surveys; statistics on smoking by type of industry; and self-assessment using toll-free lines offered by agencies such as the ACS and the American Lung Association (ALA).

5) Triggers for quitting smoking can vary, although many people quit after their first health care scare.

6) Employers have options for obtaining low-cost services outside the health plan.

Options include referring employees to the Wisconsin Quit Line; participating in Great American Smoke out events; using ACS and ALA programs; and using information offered on The Alliance Web site.

7) The cost of smoking cessation benefits can vary from 10 to 40 cents per member per month.

That means that if a company has 1,000 employees, the cost would be up to \$4,000 per month. In that scenario, just three employees need to quit for the program to break even for the year.

The cost for some medications may be in the range of \$120 a month, or roughly the same as cigarettes, although costs and dosages will vary by patient and by medication.

Group B

Moderator: Mary McNeill, McNeill Consulting

The group focused on challenges that must be addressed to increase the effectiveness of smoking cessation programs.

Highlights of the discussion included:

Companies can emphasize the cost of smoking to help engage employees in smoking cessation programs.

Company D linked smoking and health care costs to help promote tobacco cessation programs and promote its smoke-free workplace policy. When this company moved to a smoke-free campus, it notified employees three months in advance and promoted smoking cessation during that time period to give employees time to attempt to quit.

Medical professionals agree that the cost of smoking can be an important motivator that encourages people to quit.

Companies can use a non-smoking discount on health plan premiums to encourage tobacco users to quit, as long as they follow Health Insurance Portability and Accountability Act (HIPAA) rules.

Company D has introduced a high-deductible health plan that provides a non-smoking discount of \$6 a week for employees who do not use tobacco. This is in line with HIPAA rules that limit the differential in premiums between smokers and non-smokers to 20%. Additional information about the HIPAA rules is available from U.S. Department of Labor Web site (http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html).

Company E requires that all employees complete health risk appraisals (HRAs). If employees chose not to complete the coaching tied to HRA results, they do not receive the incentive tied to HRA participation.

Company F reported that some employees are working around rules tied to prescription benefits by using depression drugs as smoking cessation treatment.

Requiring spouses to participate in HRAs and smoking cessation coaching can boost the number of covered plan participants who attempt to quit.

Company F requires an HRA that involves a full blood work up to track tobacco use instead of relying on employee self-reporting. The company expects the spouse participate in the HRA along with the employee.

Group participants noted that companies should never stop inviting spouses or significant others to participate in smoking cessation programs, since getting them to quit is an

important part of helping employees quit. Again, emphasizing the cost of smoking can give employees and spouses a reason to quit. It was recommended by the medical practitioner to send letters on smoking costs home to the spouse.

Establishing a smoke-free workplace is essential if tobacco cessation programs are going to work.

All members of the group agreed with this statement, although they recognized that employers face different types of challenges based on the nature of their workforce. A company that provides professional services will have different issues than a manufacturer, for example. Further, employers have challenges around whether to pay for the employee's time while the employee is participating in smoking cessation programs.

Engaging employees in smoking cessation programs is an ongoing challenge.

Company D's biggest source of frustration remains the difficulty of engaging employees and keeping tobacco cessation messages in front of tobacco users. To date, only 25% of their smokers continue to be engaged in smoking cessation efforts. Company D uses the vendor, "Free and Clear," for its smoking cessation services.

Company E set up a broad wellness committee to encourage employee engagement, then added a wellness advocate in each department. The company reported that adding the wellness advocates has worked well. Companies were receptive to the idea of setting up the wellness committee in a manner that is similar to the safety committee.

There was broad recognition that leadership and culture really drives the approach to tobacco use or cessation.

The Alliance is an employer-owned, not-for-profit cooperative that helps its members manage the total cost of ensuring the health and well-being of their workforces. Based in Madison, Wis., The Alliance serves more than 160 member employers that provide coverage to more than 83,000 employees and dependents.
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