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**PBGH**  
Pacific Business  
Group on Health

**Tobacco Cessation Benefit  
Coverage and Consumer  
Engagement Strategies:  
A California Perspective**

June 2008 (*revised*)

### **Acknowledgements:**

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### **About the Pacific Business Group on Health**

The Pacific Business Group on Health (PBGH) is one of the nation's top business coalitions focused on health care. Our large purchaser members spend billions of dollars annually to provide health care coverage to more than 3 million employees, retirees and dependents. PBGH is a respected voice in the state and national dialogue on how to improve the quality and effectiveness of health care while moderating costs. Partnering with the state's leading health plans, provider organizations, consumer groups and other stakeholders, PBGH works on many fronts to promote value-based purchasing in health care. Reflecting the vision of its member organizations, PBGH plays a leadership role in an array of health care quality initiatives that include providing consumers with standardized comparative quality information and developing methods to assess and communicate the quality of care delivered by health plans, medical groups, physicians and hospitals. For additional information or an electronic copy of this report, visit [www.pbgh.org](http://www.pbgh.org).

# Tobacco Cessation Benefit Coverage and Consumer Engagement Strategies

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*This report has been updated to reflect the recently released 2008 US Public Health Guidelines and 2008 eValue8 Health Plan RFI responses.*



**PBGH**  
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# Introduction

Several decades of research have established the link between tobacco use and illness. Today we know that smoking and other tobacco use is a risk factor for cancer, complications during pregnancy, heart disease, and premature death. Indeed, it is the leading preventable cause of death in the United States.<sup>1</sup>

Tobacco use results in huge costs to the nation as a whole, to California, and to employers, in particular. In 2004, the estimated costs to the health-care system for treating smoking-related illness were \$96 billion for the United States<sup>2</sup> and \$9 billion for California.<sup>3</sup> Smokers consume more health care resources, experience greater absenteeism and tend to be less productive while at work. Over a lifetime, women who smoke incur \$21,500 more in medical expenses and men incur \$19,400 more than do non-smokers.<sup>4</sup> Evidence also supports investment in smoking cessation as a public health priority given quality of life improvements, savings in medical costs, and other critical factors.<sup>5</sup>

Knowledge about the health consequences of smoking and both public and private efforts to combat the addiction have resulted in dramatic reductions in the number of U.S. adults who are smokers. Nationally, smoking has declined by 50 percent since 1966<sup>6</sup>, while California has made perhaps the most remarkable progress of any state. Its adult smoking rate dropped to a historic low of 15.4 percent in 2004, a 32.5 percent decrease since 1988<sup>7</sup> when California voters passed Proposition 99, the landmark initiative that established the state's anti-tobacco program. This comprehensive law was the first of its kind to:

- Mandate smoke-free public places,
- Increase tobacco taxes,

- Create progressive local school-based tobacco education programs, and
- Fund aggressive media campaigns.

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***Smoking is the leading preventable cause of death in the United States... Over a lifetime, smokers incur \$19,400 more in medical expenses than do non-smokers.***

*US Centers for Disease Control and Prevention*

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However, in spite of these impressive gains there is still work to be done: 1 in 5 U.S. adults currently smoke, while nearly 1 in 6 Californians do. Additionally, smoking rates among youth have increased and the decline in smoking rates in the United States is leveling off, suggesting that new anti-smoking approaches may be needed.<sup>8</sup>

Private employers can play an integral role in further reducing tobacco use in California. Because approximately 66 percent of Californians receive health benefits through their place of work,<sup>9</sup> employer coverage of drug and behavioral therapies, when optimized, can facilitate the quitting process for employees and their dependents who smoke.

Studies show that the success rate of quitting is dramatically improved when people are assisted by drug and/or behavior modification therapy.<sup>10</sup> Therefore it is critical to understand: 1) what resources are available to smokers and 2) what obstacles limit access to these resources.

This report summarizes current employer coverage of smoking cessation benefits. To what degree do large California employers currently offer such benefits? Of those that offer them, what treatments do they cover?

In addition, the report summarizes our knowledge about the use of such services among employees and the barriers which may prevent them from tapping this important resource. Finally, it will highlight best practices for employer coverage of tobacco cessation support programs and services, including promising employer incentive programs to promote their use.

PBGH is in a unique position to assess the employer-based smoking cessation landscape in California. Representing 50 large California employers who provide health care coverage to more than 3 million employees, retirees and dependents, PBGH serves as a resource to support members' purchasing efforts and brings together stakeholders to address common healthcare delivery and benefit design issues. In addition, the PBGH Negotiating Alliance procures health insurance from managed care organizations on behalf of a subset of its large employer members. In the recent past, the Negotiating Alliance has undertaken an evidence-based review of smoking cessation treatments to inform coverage priorities for health benefit purchasers.

PBGH achieves these objectives by utilizing several tools. One is the standardized annual eValue8 Health Plan Request for Information (RFI), which is used to assess the services that plans offer to their members and to drive improvements in evidence-based benefit design. EValue8 enables PBGH member companies to obtain comparable information on health plan quality performance and programs such as smoking cessation services. The most recent California eValue8 results are used here to inform the extent and nature of smoking cessation services available through California health plans and offered by PBGH member companies.

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***“Supporting our employees to adopt healthier lifestyles simply makes sense - and smoking cessation can be the first step. Showing that we care enough to provide the resources strengthens Costco's partnership with employees and their dependents and will hopefully help them meet their goals.”***

***-Donna Sexton  
Director of Employee Benefits  
Costco Wholesale Inc.***

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In addition, a member employer survey<sup>i</sup> was used to assess what additional services or strategies employers may be using to address smoking among their employee populations. This survey examines employer understanding of their tobacco-using population, adoption of smoke-free workplace policies, work-based incentive programs for smoking cessation, employer working knowledge about the specific details of their health plans' coverage, and other interventions.

These data provide a snapshot of how large California employers are currently addressing tobacco use among their workforce and lays the groundwork for further research in this area.

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<sup>i</sup> The survey was developed and fielded by PBGH in addition to the scope of work supported by the CDC and National Business Coalition on Health.

# Treatment Interventions and Evidence

More than two-thirds of California smokers say they want to quit. Unfortunately, nicotine addiction can be very difficult to overcome without help. As researchers have documented, relapse rates for those who attempt to quit smoking are high, but the impact of each successful attempt is extraordinary in terms of both costs and life years saved. After 10 to 15 years, a previous tobacco user's risk of premature death approaches that of a person who has never smoked. About 10 years after quitting, an ex-smoker's risk of dying from lung cancer is 30 percent to 50 percent less than the risk for those who continue to smoke.<sup>11</sup> Today, available treatments can vastly enhance smokers' ability to successfully quit. In fact, by some estimates, intensive treatment that combines pharmacological interventions and behavioral counseling more than doubles quitting success rates.<sup>12</sup>

Health plans' role is to provide appropriate and accessible coverage for an effective array of services available to the consumer when the consumer is ready to change. The providers' role is to manage the delivery of a spectrum of treatments that best match the consumers' need and readiness-to-change state.

What treatments offer the most benefit and what are the coverage parameters and provider context that best support those treatments? Relative to the provider setting, the Agency for Health Care Policy and Research recommends that smoking cessation interventions include the following steps:

- Ask about the patient's current tobacco use,
- Advise on the importance of smoking cessation,
- Assess interest in smoking cessation,
- Assist in patient education and goal-setting, and
- Arrange for follow-up support or visits.

In other words, the first step is to identify smokers by asking about their behavior. Providers should then advise smokers to quit smoking while also assessing their interest in quitting. For those who wish to quit, providers should offer brief counseling, advise patients of their treatment options, and help patients set a quit date. Finally, for those smokers who want further help, providers should arrange for effective pharmacotherapy and/or behavioral interventions.<sup>13</sup>

## Behavioral Treatment

There is clear evidence that person-to-person contact via a group session, telephone counseling, and one-on-one support can be effective interventions. In addition, Web-based counseling may offer significant benefits, however there is evaluative work to be done with that newer and evolving intervention. With behavioral therapy, effectiveness increases with both frequency and duration of counseling.<sup>14</sup>

**Physician Counseling** One-on-one counseling from a trusted health care professional can help smokers quit. A recent meta-analysis of studies on provider counseling interventions revealed that receiving advice from any health care professional produced increases in quit rates. Using multivariate analyses of intervention effects on cessation, the same study showed that physicians were most effective, followed by multi-provider teams, dentists, and nurses.<sup>15</sup> Moreover, a 1989 study on the cost effectiveness of counseling smokers to quit found that even brief advice during a routine office visit could save between \$700 and \$2,000 per year in medical costs (in 1989 dollars).<sup>16</sup>

## A Gold Standard for Tobacco Dependence Treatment

The U.S. Public Health Service advocates six purchaser “system change” strategies to impact tobacco dependence:

1. Identify smokers.
2. Support provider interventions with education, resources, and feedback.
3. Provide tobacco dependence treatment and evaluate performance.
4. Promote policies and services for inpatients capitalizing on teachable moments and a smoke-free environment.
5. Cover pharmacotherapy and counseling services (insurers).
6. Include provision of cessation interventions among clinicians’ defined duties and reimburse for provision of tobacco dependence treatments.

The “Purchaser’s Guide to Clinical Preventive Services: Moving Science into Coverage” is a comprehensive compendium of preventive services, documenting important attributes of effective coverage. The work is a joint project of the Centers for Disease Control and Prevention and the National Business Group on Health (<http://www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf>).

Coverage recommendations include:

1. Screening is covered at every clinical encounter.
2. Eligible patients may access two courses of six counseling sessions per calendar year, for a total of 12 sessions per calendar year.
3. FDA-approved nicotine replacement products and tobacco cessation medications are covered as prescribed by a clinician and are not subject to copayments or deductible.
4. Counseling sessions should last at least 30 minutes each.
5. For optimal effectiveness, a course of treatment should support up to 300 minutes of counseling.

**Telephone Counseling.** Given that some smokers are reticent to participate in individual or group counseling, telephone support can reach a certain proportion of patients.<sup>17</sup> California has a well-respected, free, and effective state quit line (The California Smokers’ Helpline), which has been in operation since 1992 and actively promoted by several health plans.

Telephone counseling can be done proactively or in response to inbound calls. A recent survey of state quit lines found that 90 percent offer counseling through inbound calls and 87 percent offered outbound services where counselors call smokers on a scheduled basis. Forty-three percent offered help obtaining nicotine replacement or bupropion (Zyban®) therapy.<sup>18</sup>

Moreover, researchers who conducted a “real world” controlled experiment of the California Smokers’ Helpline found that callers who received telephone counseling had approximately double the abstinence rates compared to callers who did not receive telephone counseling.<sup>19</sup>

**Group Therapy.** Group therapy, which is usually more cost-effective than individual counseling, is also a proven intervention. Specifically, a meta-analysis of 55 studies found that there was an increase in cessation with the use of group therapy, and that it offered improved results over self-help interventions and other less intensive approaches.<sup>20</sup> However, telephone counseling tends to be utilized at higher rates.

**Online Support.** This newer type of intervention shows promise as a cost-effective cessation approach. It’s been documented that 80 percent of Internet users have searched at least one health site and 6 percent of those, or about 7 million people, have accessed smoking cessation information online.<sup>21</sup> Websites like [www.QuitNet.com](http://www.QuitNet.com) used by some commercial health plans sponsor social networks that combine online community support with other recommended therapeutic interventions to optimize users’ cessation efforts.

A limited number of studies have been conducted to assess the effectiveness of interactive online support and Web-facilitated social networks. One study found that abstinence increased for individuals who logged on to a Web-based program that was tailored to their specific needs (versus a more generic program).<sup>22</sup> Similarly, a randomized control trial of 351 smokers found that at 90 days, those who used an internet-based smoking cessation program had more than three times the success rate of those in the control group (28 percent versus 8 percent).<sup>23</sup> The use of online interactive support is a therapy that warrants follow-up as more research evidence emerges.

## Pharmacotherapy

Tobacco cessation treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. Clinicians generally refer to FDA-approved smoking cessation pharmacotherapies in terms of first line and second line treatments. First line treatments include nicotine replacement therapy (gum, inhaler, nasal spray, patch and lozenge) as well as the medications bupropion SR (Zyban<sup>®</sup>) and varenicline (Chantix<sup>®</sup>). Additionally, two second-line drugs that have evidence of effectiveness are Clonidine and Nortriptyline, but 1) the FDA has not approved them for a tobacco dependence treatment indication, and 2) there are concerns about potential side effects. Second-line medications should be considered for use on a case-by-case basis after first-line medications have been used without success or are contraindicated.<sup>24</sup>

One estimate of effectiveness showed that Nicotine Replacement Therapy (NRT) doubled cessation

rates.<sup>25</sup> **Table 1** below summarizes available first-line pharmacological therapy. Certain combinations of first-line medications have been shown to be effective smoking cessation treatments:

- Long-term (> 14 weeks) nicotine patch + other NRT (gum and spray),
- The nicotine patch + the nicotine inhaler, and
- The nicotine patch + bupropion SR (Strength of Evidence = A)

Decisions about use of a medication combination may be based on considerations other than abstinence. Evidence indicates that a combination of medication may result in greater suppression of tobacco withdrawal symptoms than does the use of a single medication. Additionally, some combinations of medications may produce more side effects and cost more than individual medications.

## Combining Counseling and Medication

While both counseling and medication have demonstrated independent effectiveness, the combination of counseling and medication is more effective than either alone. A comprehensive review from meta-analyses of studies has shown when counseling is added to medication, abstinence rates increased from 21.7 to 27.6 percent and when medication is added to counseling, abstinence rates increased from 14.6 to 22.1 percent. Because of these increases are significant, combining counseling and medication, while more expensive, may offer more value.<sup>26</sup>

In summary, this evidence reinforces the need for health plans and employers to include counseling and pharmacotherapeutic treatments as a covered benefit.

**Table 1. Prescription and Over-the-Counter Tobacco Cessation Medications<sup>27</sup>**

Type	Form	Common Brand Name(s)	Availability
<b>Nicotine Replacement Therapy</b>	Gum	Nicorette <sup>®</sup>	Over-the-counter (OTC)
	Patch	Nicoderm <sup>®</sup> Habitrol <sup>®</sup> Prostep <sup>®</sup> Nicotrol <sup>®</sup>	OTC and prescription
	Inhaler	Nicotrol <sup>®</sup>	Prescription
	Nasal Spray	Nicotrol <sup>®</sup>	Prescription
	Lozenge	Commit <sup>®</sup>	OTC
<b>Bupropion SR</b>	Pill	Zyban <sup>®</sup> Wellbutrin <sup>®</sup>	Prescription
<b>Varenicline</b>	Pill	Chantix <sup>®</sup>	Prescription

# Treatment Coverage

Increasingly, employers recognize that smoking takes a toll on workers' health and productivity. For example, research shows that men who smoke miss 4 more days of work than those who do not smoke,<sup>28</sup> and adult smokers cost employers at least \$1,760 per year in lost productivity and \$1,623 in excess medical expenditures.<sup>29</sup> In fact, a recent CDC report concluded that, "paying for tobacco use cessation treatments is the single most cost-effective health insurance benefit for adults that can be provided to employees."<sup>30</sup>

Indeed, the question for many California employers is not whether to cover, but how to cover smoking cessation, and how to maximize utilization of available benefits. Cessation services can be offered internally, covered through a self-funded ERISA plan, or covered via health insurance purchased from managed care organizations or health insurance carriers. Benefits vary by the type of treatments covered (i.e. coverage of prescription drugs), by the health plan offering (i.e., various plans structure behavior change offerings differently ranging from comprehensive one-to-one in-person or telephone counseling options to newer self-initiated Website tools), and by the design of the employer's benefit such as the degree of enrollee cost-sharing.

How to cover smoking cessation benefits is a subject of much debate. However, there is research to guide employers in determining the most efficacious and cost-effective way to cover this high-impact preventive service.

## Copayments and Out-of-Pocket Costs

There is evidence to indicate that even modest copayments and out-of-pocket costs can be a barrier to cessation services. In fact, after reviewing the literature on this subject, the Task Force on

Community Preventive Services recommends reducing or eliminating out-of-pocket costs in order to increase use of smoking cessation treatments.<sup>31</sup>

Several studies support this position. In a longitudinal, natural experiment, health services researchers at Group Health Cooperative in Seattle compared the use and cost effectiveness of three forms of coverage with varying levels of cost-sharing for smoking cessation benefits. Results showed that use of smoking-cessation services varies according to the extent of coverage, with the highest rates of engagement among smokers with full coverage.<sup>32</sup>

A second study came to similar conclusions. UC Berkeley researchers randomized 1,204 smokers enrolled in two IPA model HMOs in California either to the control group, which received a self-help kit (video and pamphlet), or to the treatment group, which received the self-help kit and fully covered benefits for over-the-counter nicotine replacement gum and patch, and participation in a group behavioral cessation program with no patient cost sharing. After one year, quit rates were 18 percent in the treatment group and 13 percent in the control group.<sup>33</sup>

However, the conclusion that cost-sharing should be minimized for tobacco use cessation is at odds with some plan designs that expand patient cost-sharing in order to promote consumer engagement, decision-making and prudent utilization of discretionary health care services. Thoughtful purchasers recognize that a quality-based or value-based benefit design strategy that covers preventive treatments such as smoking cessation can deliver substantial health dividends.

For a comprehensive assessment of empirical evidence to date relative to value-based benefit

design, readers can review “Assessing Quality-Based Benefit Design” ([http://www.pbgh.org/programs/documents/PBGH-CHCFQualityBen DesignPWC-04-2006.pdf](http://www.pbgh.org/programs/documents/PBGH-CHCFQualityBen%20DesignPWC-04-2006.pdf)). The report addresses multiple aspects of benefit design including cost-sharing for pharmacological maintenance drugs and considerations for health promotion and incentives to reduce high-risk behaviors.

## Contingent Coverage

In 2001, CDC researchers examined the question of whether coverage of behavioral therapy should be conditional upon pharmacotherapy use (or vice versa), since the two treatments are most effective when done together. They concluded that since many smokers are unwilling to participate in behavioral interventions, tying pharmacotherapy and behavioral interventions together may serve as a barrier to smokers motivated to quit, and therefore recommended against it. The recommendation was supported by UC Berkeley researchers who in 2006 concluded that contingent coverage increased cost with no corresponding increase in quit rates.<sup>34</sup>

## Over-the-Counter Therapies

Another common consideration for employers is whether to cover over-the-counter pharmacotherapy. Purchasers can maximize their employees’ access to effective treatments if they do, because over-the-counter drugs are easy and convenient to purchase. Moreover, they are often less costly than prescription alternatives. For some plans, administering reimbursement for over-the-counter purchases is burdensome. Additionally, plans have reported fraudulent use (e.g. benefit transfer) when reimbursable coverage is provided for over-the-counter aids. Employer plan sponsors and insured health plans should carefully evaluate the pros and cons of such a practice, still used in the minority of situations.

Coverage of effective smoking cessation interventions will promote use of effective therapies and will result in reduced smoking rates. For this reason, health plans play a key role in improving quit rates among California employees – the topic of the subsequent section.

## Driving Value-based Benefit Design: The PBGH Negotiating Alliance

The PBGH Negotiating Alliance is an employer coalition that purchases health care from managed care organizations. In 1999, the Alliance reviewed its coverage of treatments to aid smoking cessation. Though the Alliance offered benefits, purchasers saw the opportunity to provide enhanced coverage based on the evidence.

Led by Jeff Harris, MD, MPH, then a researcher with the Centers for Disease Control, PBGH synthesized evidence from the academic literature and interviews with plans and employers. The effort culminated in a benefit design recommendation that included coverage for drugs and behavior change therapy with: 1) reduced or no copayments, and 2) no contingency for behavior modification participation in order to access drugs.

As thought leaders in value-based benefit design, Alliance employers embraced these recommendations

and expanded their coverage for behavior modification, prescription drugs and selected over-the-counter aids. However, based on input from an advisory committee of health plan medical directors who sought to maximize program efficacy, the core design incorporated a requirement for use of counseling services. As a result of PBGH efforts, plans adjusted their basic benefit design and have, to varying degrees, adopted the PBGH recommendations over the years.

PBGH employers set a trend with this new level of coverage, but future steps must address utilization and member engagement – it is not enough to offer coverage; enrollees need to use the services to garner their benefits. The next priority for the Negotiating Alliance will be to address the key challenges of communications and outreach.

# Health Plan Smoking Cessation Initiatives and Performance

Most employers rely on health plans to manage the delivery of smoking cessation services. Two primary sources provide insight into the nature and performance of health plan programs. This report draws from HEDIS data and from the 2007 PBGH eValue8 "Request for Information" health plan responses to understand the current state of health plan services and performance.

A standardized annual Request for Information (RFI) administered in partnership with the National Business Coalition on Health, eValue8 provides an objective and qualitative view of health plan services. Results from the 2008 eValue8 survey representing 2007 activities show the extent and nature of smoking cessation services offered by plans that contract with PBGH member companies (**Appendix 2**). These include four HMOs – Health Net, Kaiser Permanente-North, Kaiser Permanente-South, and PacifiCare – as well as four PPOs – Aetna, Anthem Blue Cross, CIGNA, and UnitedHealthcare.

## Identifying Smokers<sup>2</sup>

HMOs or Health Maintenance Organizations have aligned incentives via provider payment mechanisms and other means to promote the maintenance of health with proactive preventive care, in part through systematic population management. This ideally includes targeted outreach to select subgroups with meaningful messaging to specific enrollees. Identifying smokers is an important first

step to reaching them with messaging and treatment offerings, as well as to measuring the impact of interventions.

However, with the exception of the Kaiser HMOs (see sidebar), plans are not systematically identifying smokers among their enrollees. This is due in part to the structure of network model HMOs in California, where a delegated model of care removes the HMO from routine direct contact with treating physicians. Moreover, the delegated model does not support electronic or system-wide access to medical records. Exacerbating the problem is the lack of routine coding for Tobacco Use Disorder (ICD 305.1). If used, the code could be included in batched encounter data submissions and would facilitate data mining to identify subpopulations of smokers/tobacco users for targeted outreach. Use of ICD 305.1 is rare and California plans do not currently mine data for this code.

Changes to the CPT coding system (Common Procedural Terminology by which providers bill for services) scheduled for January 2008 support new codes as a mechanism for identifying smokers. Evaluation and management (E&M) codes 99406 and 99407 are specific to smoking cessation counseling. However, in California's mostly capitated marketplace, use of such codes will likely not be rewarded with increased reimbursement, and therefore will be difficult to promote. It is noteworthy that Medicare does reimburse for these codes and can serve as a model for commercial health plan payment for this category of service.

Pharmacy data are more generally integrated with other clinical data and used to identify subpopulations. Given the availability of prescription

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<sup>2</sup> See the appendix for comparative tables of health plan coverage, identification, and measurement parameters. Blue Shield of California did not participate in the 2007 eValue8 Health Plan assessment.

drugs for smoking cessation, pharmacy data offers an opportunity to identify those members who have exhibited some level of readiness to change (e.g., they filled prescription for nicotine replacement therapy). At the same time, pharmacy data are limited in that they do not support identification of smokers who are using only over-the-counter treatment or who have yet to act on changing their behavior. Another challenge with pharmacy data is use of the generic bupropion by patients with depression could result in false positives.

Health Risk Appraisals (HRAs) are another tool used by health plans to identify smokers. These questionnaires are generally available on health plan Web sites and are increasingly being offered directly by employers. While HRAs are a credible source of self-reported lifestyle or behavioral risks such as smoking, seat belt use, alcohol and drug use, HRAs typically have low participation rates. For this reason, they are not a meaningful method for identifying smoking rates within a population.

This limitation is underscored by eValue8 2007 data representing 2006 activity. It showed that HRA completion rates for California plans ranged from a low of 0.1 percent to a high of 12.3 percent with a median reported participation rate of 0.42 percent. These numbers might be slightly understated if one considers only the employer-covered sub-populations of health plans, but the very small numbers involved point to the limitations of HRAs in reliably identifying smokers. Indeed, health plans tend to recognize this limitation and generally don't use HRA results for outreach, but instead make it available as a self-management tool with education and referral resources during "teachable moments" when members are completing their health risk appraisal.

## Physician Outreach

Clinicians are influential advisors to smoking patients. One key piece to improving use of smoking cessation treatments is to support management of their patients. Both Aetna and Anthem Blue Cross have adopted this approach.

## Kaiser: Smoking as a Vital Sign

Administrators and physician leaders at Kaiser Permanente in Northern California recognize their integral role in driving smoking abstinence among Kaiser members. In 1998, the regional health system implemented a comprehensive program to track smoking status at every encounter. Coined "Smoking as a Vital Sign," the program aims to prioritize smoking status as a primary indicator of overall health. Moreover, the program created a protocol for physicians to inquire about and address smoking status at every physician office visit, which is the point at which a doctor has a member's attention.

The process is simple. At every encounter, a medical assistant escorts the patient to a clinical station for routine tests such as blood pressure reading, temperature, and pulse rate. At this juncture, the assistant will ask the patient if he/she smokes. All four data points are recorded and the critical data is displayed on the patient's electronic record in the exam room so that a physician can assess readiness to change, and target smokers with resources and advice to help them quit.

The strategy is paying off. For three years running, the Kaiser North region scores rank higher than other statewide California HMOs in all smoking-related metrics: Advising Smokers to Quit, Discussing Smoking Cessation Medications, and Discussing Smoking Cessation Strategies. Kaiser North's smoker identification rate reported in eValue8 2007 far exceeds that of any other health plan, most of which don't even capture a rate.

Admittedly, Kaiser's integrated system lends itself to a more orchestrated physician-wide approach and to an electronic medical record for managing such data. However, Kaiser's northern region out-performs the equally as integrated southern region in all smoking-related metrics. Systems alone don't achieve results if there isn't an operationalized and consistent effort to ask one key question: "Do you smoke or use tobacco?" The program is now being disseminated throughout other Kaiser regions.



Blue Shield offers a helpful  
Smoke-Free Program

There are many  
compelling reasons to  
quit smoking today.

You can also get help through the  
**California Smokers' and Chewers' Helplines**

The California Smokers' Helpline provides free professional and confidential telephone counseling for anyone living in California, whether you are currently addicted to tobacco, have already quit, or want information for a friend or relative.

When you call, a friendly staff person will offer a choice of services, including self-help materials. If you would like to quit on your own, visit [www.californiasmokershelpline.org](http://www.californiasmokershelpline.org).

English  
1-800-NO-BUTTS  
(1-800-662-8887)

Chew/Smokeless Tobacco  
1-800-844-CHEW  
(1-800-844-2439)

For those living outside California, you can contact the American Cancer Society or the American Lung Association for a list of referral services.

American Cancer Society  
1-800-ACS-2345  
(1-800-227-2345)  
[www.cancer.org](http://www.cancer.org)

American Lung Association  
1-800-LUNG-USA  
(1-800-506-4872)  
[www.lungusa.org](http://www.lungusa.org)



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Helping smokers quit could be one of the most important things you do as a physician. There is strong evidence that your intervention with smokers increases their odds of successfully quitting. Blue Cross of California has developed a tobacco cessation program, TLC: The Last Cigarette® Program to support you in assisting your patients with their smoking cessation efforts.

**TLC**  
The Last Cigarette®  
866-634-3435

TLC: The Last Cigarette® offers numerous resources and tools to assist your patients in their quit efforts. No matter what stage of readiness to quit your patient is in, we think you will find the information helpful for your patients. FREE TLC Quit Kits are available to all BCC members in English and Spanish.

**TLC for Young Adult Tobacco Cessation Website:**  
<http://www.tlc4ya.com> is a website dedicated to members between 14 and 24 years old. This is an addition to our TLC program and provides resources and tools suited to teens and young adults in their goal to quit smoking.

**TLC**  
**4 YA**  
For Teens and Young Adults

For example, in 2007, Aetna distributed "Advising Smokers To Quit" toolkits to more than 8,500 family practice and internal medicine physicians to improve outreach.

The kits are designed to educate physicians about the importance of a proactive approach to smoking cessation treatment and to assist them with patient communication and counseling. Each contains an action plan worksheet to help physicians and patients create a quit strategy and quit date; a list of support resources; a medication plan; educational materials for patients on how to succeed with their cessation effort; and educational materials for physicians on resources available to their patients such as telephonic support among other resources. The approach leverages the influential role that doctors play in engaging and advising the patient.

## Treatment Coverage

In general, California fully insured HMOs include some level of coverage for drugs, but broad coverage is usually contingent upon participation in a behavior change program. Some plans also use a step therapy protocol, whereby patients must attempt using the preferred, or "first step" drug before

gaining authorization for another drug. Drugs are typically prioritized into steps after some consideration of efficacy, price, side effects, etc. Online support and telephonic counseling are available through most plans. Self-insured PPOs, in contrast, offer drug coverage as a buy-up program, which is optional and dependent upon employer demand.

Among HMO plans, Kaiser North and South have the most comprehensive package of pharmaceutical and behavioral change offerings. The HMO covers all of the prescription drugs surveyed (Zyban®, bupropion, Chantix®, NRT inhalers and nasal sprays) using a step therapy protocol. Like other HMOs in California, Kaiser requires members to be enrolled in a behavior change program to access to drugs at the lowest copays. Kaiser is unique among HMOs in also providing copay-only access to over-the-counter quitting aids. Kaiser's integrated delivery model also allows a comprehensive, multi-modality, on-site approach to behavior modification. At most facilities, members have access to group sessions, workshops, and in-person individual counseling, most often available at no cost.

In a network model, large medical groups may also provide localized efforts such as sponsored

workshops and group support classes. However, health plan promotion or tracking member participation in such programs is problematic, and it can create challenges for employer communication efforts.

A number of health plans, physicians, and employers refer their enrollees to publicly funded and free smoking cessation services – namely, the California Smokers' Helpline. Other plans have developed internally administered telephonic programs or have contracted with a vendor to provide this service to members. For example, Free & Clear is one vendor used by two large HMOs in California. The program generally includes 3-4 outbound calls to the member aimed at establishing a quit plan, quit date, offering quit tips, and setting up follow-up calls. Inbound calls are also covered as part of the program. Free & Clear reports participation rates to health plans which use the data to track "identified smokers" or program participants.

In general, self-funded employers determine the scope of pharmacy coverage and can elect to "buy up" telephonic counseling or other support services. Most plans encourage coverage of over-the-counter medications with standard telephonic programs as a first step before moving to prescription therapies.

CIGNA offers a comprehensive program for all its behavioral health employer clients and as a buy-up for other CIGNA employers. The program is unique in its concentration on structured behavior change modalities. Meeting the "gold standard" in terms of counseling sessions and time, the program also offers weekly relapse support through telephonic group sessions.

Starting in 2008, WellPoint/Anthem PPO clients will have access to "Tobacco Free", a buy up program featuring behavior change with telephonic counseling support. The program is administered by Healthways and will feature online chat sessions.

Aetna routinely builds NRT into the Healthyroads program. Healthyroads, a subsidiary of American Specialty Health, provides services to those Aetna

clients who have purchased tobacco cessation behavior change services. The program features telephonic counseling sessions and routinely includes NRT over-the-counter supplies. Aetna also markets group cessation programs as a part of their worksite wellness offerings that can be purchased by clients.

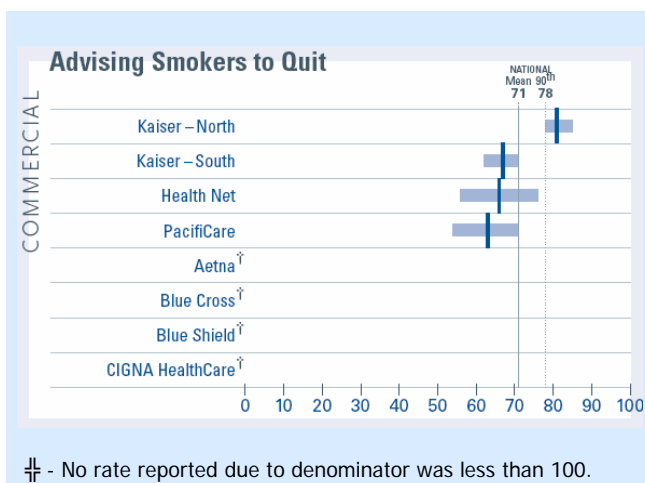
Without exception, health plans provide online support for smokers. The continuum of services range from general education and resource referral to interactive programming that includes development of a customized quit plan, daily logs, and self-analysis and management of personal triggers. Described earlier, Wellpoint/Anthem's QuitNet is the engine behind online chat sessions. Another PPO, UnitedHealthcare, supports interactive online "chat" sessions that are real time between the patient and the virtual counselor. Although this latter buy-up program is not tobacco-cessation specific, its professionally facilitated sessions enable 24/7 support for behavior change.

## **Performance Measurement: HEDIS**

The Healthcare Effectiveness Data and Information Set (HEDIS) are metrics used by more than 90 percent of America's health plans to assess performance on important dimensions of care and service. Administered by NCQA, HEDIS includes a patient survey called the Consumer Assessment of Health Plans Survey (CAHPS) that includes questions about smoking history. The survey asks current smokers and recent quitters about whether they have been advised by their provider to quit smoking in the past 12 months. In 2006 (reported on the 2007 CAHPS survey), 73.8 percent of smoking patients enrolled in a private health plan (nationally) reported they were advised to quit smoking from a clinician.

The CAHPS survey asks patients who smoke to report if their doctor discussed cessation strategies, including drug medications, with them. In the 2007 survey results, 43.9 percent of patients reported that their doctor discussed medication options for smoking cessation with them, while 43.2 percent discussed other cessation strategies.<sup>35</sup>

**Table 2. 2007 California HEDIS Results**



HEDIS scores for California plans and providers are reported by California Cooperative Healthcare Reporting Initiative (CCHRI), a PBGH-administered collaborative of health care purchasers, plans and providers that collects and reports standardized health plan and provider performance data. For two of the three measures, discussing medications and discussing strategy, California performed better than the national average for the most recent year. Data for four HMO plans were not reported publicly due to an insufficient number of identified smokers, perhaps reflecting California’s overall lower prevalence of smokers and long history of anti-tobacco campaigns.

One noteworthy finding is that Kaiser North, the health plan with the most proactive strategy for identification of smokers, scored in the 90<sup>th</sup> percentile nationally for advising smokers to quit. Kaiser North includes a data point in the electronic medical record for physician attention at time of visit, a practice now being implemented by Kaiser South (see box above).

In the past, HEDIS has been tied to accreditation of HMOs or managed care organizations. Consequently, PPO performance measurement has largely been voluntary and not been reported publicly. The patient self-referral structure of PPO networks introduces performance measurement challenges, and historically PPO participation in CAHPS/HEDIS

has been voluntary. Among PPOs, Anthem Blue Cross is the only plan that conducted the CAHPS measurement in California for 2007.

Recognizing a need for better information about PPO plans, the California Department of Insurance recently expanded its healthcare report card program to include PPOs (August 2007). Health plans have agreed to extend HEDIS/CAHPS measurement to these types of plans in 2009, which will result in a significant improvement in our knowledge about how California PPOs are performing vis-à-vis each other and HMO plans.

### Tracking Quit Rates

Comparing quit rates of various programs is difficult due to varying methodologies. Typically quit rates are self-generated by health plans or programs and are unaudited. Additionally, because the rates are calculated based on self-reported patient accounts, the room for error is exacerbated. It is critical to consider if individuals whose post-program smoking status is unknown are counted in both the numerator as smokers and in the denominator as program participants. This algorithm is the most conservative approach. Alternatively, some quit rates omit non-responders from both the numerator and denominator, which is likely to overstate program success. Assuming the quit rate of non-responders is equal to those who self-report also overstates success rates.

Kaiser tracks quit rates among its enrollees, with Kaiser North and South recording a 54 percent 6-month member-reported quit rate. Both Kaiser plans used the conservative methodology when calculating these rates, including non-responders in the participation denominator. CIGNA is the only PPO plan that tracks 6-month and 12-month quit rates among its smoking patient population, also reporting use of the conservative calculation approach, although these are national, not California-specific data.

# Large Purchaser Coverage and Initiatives

CDC cost analyses show that smoking cessation benefits are either cost-saving or cost-neutral over a period of 3 to 5 years.<sup>36</sup> Nevertheless, a recent national survey of employers found that only 24 percent offer any coverage for tobacco use treatment and only 4 percent provide coverage for both medication and counseling.<sup>37</sup> In California, coverage is higher because more health plans include such benefits.<sup>38</sup> A 2001 study found that 69 percent of California HMOs cover at least one form of pharmacotherapy and one type of counseling to treat tobacco dependence.<sup>39</sup> Moreover, a 1999 survey of California employers found that roughly half covered smoking cessation treatments, although the coverage varied by type of health plan, treatment and size of employer.<sup>40</sup>

PBGH member companies were surveyed about their policies and coverage availability. The results provide a snapshot of current coverage practices among large employers (those with over 2,000 eligible covered lives). Among PBGH members with national populations, the benefits coverage is generally consistent. However, the results probably do not broadly represent national coverage practices as California has historically assumed a more aggressive stance on smoking cessation and the state's smoking prevalence is already among the lowest in the country.

## Prevalence Measurement

Results show that only approximately half of PBGH members currently measure smoking prevalence among their employee populations. Because the data are heavily reliant on voluntary member self-reported information, smoking status is burdensome to collect and maintain. Furthermore, purchasers may focus on other health risk factors and conditions given the relatively lower rate of smoking in

California. Prevalence of conditions like diabetes that have more discrete pharmacy and claims data identifiers are more often measured by employers and health plans. Intervention efforts for tobacco cessation may be stymied or ineffectively targeted without important baseline prevalence data. Of those that do measure prevalence, an average rate of <11.5 percent was reported in this survey. This rate is lower than both the national average (20.9 percent)<sup>41</sup> and the California rate (15.4 percent).

Among survey respondents, employers indicated that none of their health plans report prevalence rates. Indeed, prevalence is not a routine reporting point for health plans and is likely made available only for employers with HRA initiatives whereby smokers are offered an incentive to participate in cessation activities. Earlier in this paper, the shortcomings of using Health Risk Appraisals (HRAs) as a means of measuring prevalence were discussed. In some cases, health plans may report program participation rates, but these should not be construed as prevalence.

## Identification of Tobacco Users

Like health plans, many employers rely upon a Health Risk Appraisal questionnaire to identify smokers and tobacco users. Although some employers have achieved high rates of completion with an incentive, HRAs are generally limited by low voluntary completion rates. Furthermore, there is selection bias in that healthy and non-smoking people are more likely to complete an HRA. In a few cases, employers extrapolated from national figures using the demographic characteristics of their workforce to estimate smoking prevalence. Others use life insurance enrollment forms, a question on open enrollment materials, and analysis of prescription drug use data to ascertain worker tobacco use.

Congratulations on...

## ...Your Decision to Stop Smoking.

CalPERS is contacting all members who have a new prescription for smoking-cessation aids. We want to let you know what your benefits are so you can make informed decisions about your healthcare as it pertains to smoking cessation.

Your current medical benefit administrator is Blue Cross of California. The Plan will cover up to \$100 per calendar year for behavior-modifying counseling or classes or alternative treatment, such as acupuncture or biofeedback for the treatment of nicotine dependency or tobacco use. See your 2007 Evidence of Coverage booklet under "Smoking Cessation Program" for further details.

Blue Cross of California has developed a tobacco-cessation program, TLC: The Last Cigarette<sup>®</sup>, to support you in your smoking-cessation efforts. You can also access this program on the Web at [www.bluecrossca.com/calpers](http://www.bluecrossca.com/calpers).

Help for **Teen Smokers**



### CalPERS: Targeted Interventions Using Prescription Drug Data

The California Public Employees' Retirement System (CalPERS) uses prescription drug data to proactively engage members and offer them an incentive for continued efforts to quit smoking. Through Anthem Blue Cross, which administers the self-funded PPO and Medco, which manages the pharmacy benefits, enrollees who filled a prescription for smoking cessation aids are identified. Members then receive communications offering a \$100 credit towards behavioral modification including acupuncture and biofeedback. Such an approach optimizes the effectiveness of the outreach by targeting engaged members interested in trying to quit smoking.

The communications also alert the member to the full extent of their benefit coverage and other

services available through Anthem Blue Cross, such as telephonic counseling and a popular "Quit Kit". Importantly, the flier also lists resources targeted at teen smokers who reside in the same household.

The CalPERS communications effort was launched in May 2007 and data about member uptake, impact, and member satisfaction are not yet available. However, preliminary data indicate that almost 4,000 members were eligible for the incentive within the first five months of its offering. CalPERS operationalizes the \$100 incentive program by allowing employees to obtain the reward if they submit a receipt for any type of cessation-related service not currently covered by their plan.

**Prescription Data.** The fact that few employers are making use of prescription drug data merits further attention. Self-funded employers and those that “carve out” the pharmacy benefit generally have access to pharmacy data, which given the limitations of procedure code documentation in claims data previously discussed, is the best opportunity to identify smoking-related health services. The data provides evidence of a filled prescription for Zyban<sup>®</sup>, Chantix<sup>®</sup>, or bupropion, indicating that a member has filled a prescription and might be ready to change. For the most part, employers are not taking advantage of this data. The few that do use it to analyze drug trends, estimate smoking rates, quantify coverage uptake, and to target outreach.

## Workplace Smoking Policies

California is unique among many other states in that it has put in place strict laws governing smoking in indoor and outdoor public places. California employers are likely ahead of the curve compared to other large and small employers nationally for that reason – by definition all have formal policies forbidding smoking in workplace buildings. One-third of the survey respondents go a step further and have extended their smoke-free policies to include both internal and external areas or entire work campuses. One-quarter also have policies that prohibit smoking in company vehicles. Given that such policies have the potential to cause a backlash from employees who smoke, large employers tend to roll them out one campus at a time or to pilot them before disseminating them throughout the company.

Most employers don't indicate intent to change their current policies around smoking, but those that do are generally considering expanding coverage for drugs, moving to smoke-free grounds, and considering smoking status in formulas for premium contributions. No PBGH employer has an explicit policy against hiring smokers, although employers in other states have used such a strategy. Importantly, California employers tend to focus on cigarette-smoking rather than the full spectrum of

tobacco use behaviors. An area for future attention is smokeless tobacco (chewing tobacco and snuff) use, which although declining in prevalence, is associated with an elevated risk for oral cancer – a disease with a very low 5-year survival rate.<sup>42, 43</sup>

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***The smoking cessation program at Pitney Bowes is paying off. The comprehensive program resulted in a 50 percent quit rate after one year, the telephonic program achieved a 42 percent quit rate.***

***-Mary Bradley  
Director of Health Care Planning  
Pitney Bowes***

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## Incentives

The PBGH survey queried purchasers about their use of premium discounts, premium surpluses, and cash/gift/HSA/other “reward” incentives. In some cases incentives are broadly focused on wellness programs and not targeted specifically at smoking cessation, e.g., incentives for completing an HRA and/or participating in health risk reduction programs. However, more than half of employer respondents reported use of an incentive reward for non-smoking status and use of enticements to reward participation in smoking cessation programs. In fact, at least for the first year of a program, virtually every employer who had a smoking status-based incentive, i.e. rewarding non-smoking employees, also reward participation in smoking cessation efforts. In most cases, the incentives are targeted at the employee and do not extend to adult dependents.

Over half of the respondents to the survey have a range of incentive programs that vary by health plan enrollment. This patchwork of service coverage, offerings, and incentives creates challenges for employers interested in reaching employees with outreach efforts and new universal coverage policies. Indeed, the complex messaging needed to

communicate plan programs to each enrollment group is an obstacle to employers' proactive engagement of members about plan offerings.

Some U.S. employers have opted to charge smokers more for their health coverage under the rationale that they use more health care resources. However, no PBGH employer has currently adopted this practice. When a PBGH employer offers a premium discount to non-smokers, the same discount is also available (at least for the first year) to smokers who participate in a cessation program. In general, premium discounts are still not as widely used among PBGH members as award incentives, which include a range of inducements such as cash, gift cards, or HSA/HRA/FSA credit. Most of the employers that indicated use of an incentive reward provide some support of OTC or other cessation aids – i.e. behavior change therapy or alternative treatments.

Employers designing an incentive program around tobacco use must consider the issue of equity and the culture of their workplace. Awarding participation in cessation programs with cash, gifts, or premium discounts without rewarding non-smoker status can cause “employee noise” among the “healthier” non-smokers who feel cheated by the practice. Likewise, rewarding non-smoker status without allowing rewards for effort (cessation participation) might be ill-received. Moreover, gifts and cash rewards for participation in cessation programs may create a perverse incentive for employees to repeatedly enroll or to feign smoking status in order to capitalize on the reward. For this reason, one PBGH employer ceased its participation award after one year and now only awards non-smoking status. Their rationale was to provide one-time support for the motivated smoker to quit, but ongoing reward only for those with a non-smoker status. Another way to address this issue is to limit incentives to a one-time opportunity. Note that elsewhere in this paper it is reported that coverage guidelines recommend coverage for multiple courses of treatment, incentive policies need not be consistent.

## **Pitney Bowes: Incentives and Rewards**

Pitney Bowes has employed a variety of “quit smoking” initiatives with impressive results. As part of the Count Your Way to Health Program offered by Health Care University, the company's health improvement program, employees can earn dollars towards their benefits coverage by participating in a company sponsored tobacco cessation program which includes free nicotine replacement therapy (NRT). Employees can earn additional dollars for other healthy behaviors such as exercising regularly, and eating fruits and vegetables.

As part of a larger strategy to improve employee health and lower costs through more comprehensive coverage of chronic disease medications and preventive treatments, the company built seven on-site health centers where the tobacco cessation program has been implemented. Employees outside these seven sites can obtain quit help through a national telephonic quit program, which also includes counseling, and NRT.

While in 1991, Pitney Bowes implemented a ban on smoking in all workplaces, the company's general philosophy on wellness is about rewarding the positives rather than punitive measures. The credits that employees earn through Health Care University are in the form of flex dollars used to purchase their medical benefits.

Data suggest the program is paying off. The comprehensive program is delivered through two on-site clinics that includes free NRT and bupropion treatment, referrals to counseling, educational materials, and structured follow-up. It resulted in a 50 percent quit rate after one year. Additionally, a 42 percent quit rate has been achieved through the telephonic program.

The majority of these programs are new and it's too soon to tell if they will become longer-term initiatives, how they may differ from year to year, if they will deliver a return on investment, or succeed in motivating more employees to quit.

## Knowledge of Plan Coverage Options

In order to illustrate the challenge of managing different coverage levels from different health plans addressing different population sub-sections, the PBGH survey asked employers what coverage is available through their health plans. The survey revealed that employers largely don't know exactly what services their health plans are providing. For instance, over half of the respondents did not indicate that Kaiser, PacifiCare, and/or Health Net offer one-to-one telephonic counseling when in fact all three make that service available. However, respondents consistently reported that Kaiser offers members group classes, and this may indicate that Kaiser has done a better job communicating their program to employers.

The same holds true with HMO prescription drug coverage. The eValue8 RFI of health plans shows that PacifiCare covers Zyban<sup>®</sup> and bupropion but not Chantix<sup>®</sup>, that Health Net covers all of these medications at the 50 percent level, and that Kaiser covers all in a "step therapy" treatment modality. But employers were generally not clear on what prescription drug coverage is offered. Respondents expressed a slightly better knowledge about drug coverage through Kaiser. For example, Kaiser is the only HMO that supports discounts on over-the-counter medications and about half of the respondents knew this fact. In contrast, PacifiCare allows a discount for [www.QuitKey.com](http://www.QuitKey.com) (an OTC tool that supports an individualized quit plan), but only one employer was aware of this offering.

## Employee Utilization

In 1999, the prevalence of smoking among enrollees of health plans that participated in the California

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*"At Stanford, we think that a lower-than-average smoking rate is still too high. Through a joint health plan communications campaign, we made it easy for our employees to know the various tobacco cessation resources available. The University also sponsors a program as another option to help employees achieve a smoke-free life."*

*-Elaine Chiu  
Senior Benefits Analyst & Project Manager  
Stanford University*

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Cooperative Healthcare Reporting Initiative (CCHRI) was estimated at 13 percent<sup>44</sup> based on CAHPS survey data. However, employee utilization of smoking cessation benefits is something of a "black box." Some data is available from eValue8, which in 2007 (representing 2006) shows that among commercial enrollees, participation in cessation activities ranges from .01 percent (or less) to 0.3 percent of the insured population. These low rates reflect measurement challenges although low participation rates are likely the reality. When services are accessed through medical groups in a network model HMO, the plan does not have the capability of accounting for accurate participation. Additionally, due to coding and other information collection challenges discussed earlier in this paper, data mining for participation is difficult at best and may be reliant on pharmacy data, which provides an inconclusive picture of overall coverage options.

EValue8 and other data sources suggest that employee coverage is underutilized, but much more research is needed in this area to fully understand if, when, and why employees use smoking cessation benefits. One opportunity is the preponderance of employer-administered incentives discussed here. Future research attention is needed to analyze the results of those efforts.

# Stanford employees, are you ready to kick butt?



Smoking Cessation Tools:

HealthCredits<sup>®1</sup> is an interactive online program that provides

If you smoke, chances are you already know reasons why you should quit. You've probably thought about it. But it's only when you're ready! Are you ready?

A strong desire to stop smoking is essential. You will be in quitting.

**Where to Get Help From Stanford's Quit Tobacco Program** – Stanford provides free educational and counseling. As part of The Quit Tobacco Program, you may select from:

- One-on-one counseling session
  - A 20-minute phone call to approach that will work for you
  - A 60-minute one-on-one session to receive a work plan and tips and receive a work plan
  - Up to 11 follow-up phone calls
- Group counseling session
  - A 20-minute phone call to approach that will work for you
  - A 60-minute one-on-one session to receive a work plan and tips and receive a work plan
  - 6 group sessions to receive a work plan and tips and receive a work plan
  - 4 follow-up phone calls

## If you smoke, it's time to stop!

As part of Stanford's Wellness campaign, the Benefits Department has partnered with our medical plans and the Health Improvement Program (HIP) to provide various ways to help you stop using tobacco.



### Why is Stanford committed to this program?

Tobacco use is the world's leading cause of preventable death, accounting for 10% of adult fatalities, according to the World Health Organization. The use of tobacco – in any form – has been proven to cause many debilitating conditions such as heart disease, heart attacks, strokes, various forms of cancer, neurological disease, emphysema and other lung diseases. Since nicotine is one of the most addictive substances known, tobacco users are much more likely to quit when they get help.

The Quit Tobacco Program

**From Your Medical Plan** – All of Stanford's medical plans offer programs and coaching assistance to help you quit tobacco use. These programs are available to you and your covered family members. Your cost will depend on the program you select and prescription drug aids prescribed. Check on costs with your doctor's office or by calling the Member Services number on your medical ID card. Here's some of what's offered.

Your medical plan	What is offered
Blue Shield	<ul style="list-style-type: none"> <li>■ Online Smoke Free Program offered through Healthy Lifestyle Rewards</li> <li>■ Coverage for some prescription drugs to help stop tobacco use</li> </ul>
Health Net	<ul style="list-style-type: none"> <li>■ Telephone one-on-one support through Free &amp; Clear's Quitting Matters program</li> <li>■ Online support through QuitNet or WebMD</li> <li>■ Coverage for some prescription drugs to help stop tobacco use after enrollment in smoking cessation program</li> </ul>
Kaiser Permanente	<ul style="list-style-type: none"> <li>■ Online Quit-Smoking Program through HealthMedia Breathe</li> <li>■ Various in-person workshops and support groups held at Kaiser facilities</li> <li>■ Coverage for some prescription drugs and the nicotine patch to help stop tobacco use after enrollment in behavior modification program</li> <li>■ Discounts for some over-the-counter aids</li> </ul>
PacifiCare	<ul style="list-style-type: none"> <li>■ Telephone one-on-one support through Free &amp; Clear and coverage for some prescription cessation drugs upon enrollment in smoking cessation program</li> <li>■ Discounts for hand-held quitting aid, Quitkey</li> </ul>

## Stanford University Outreach and Communication

Many employers fail to effectively communicate to employees the benefits available to them from health plan vendors. Stanford University recognized this missed opportunity and launched a communication effort in 2007 to help dispel enrollees' confusion and lack of awareness about different health plan offerings. Stanford's objective was to encourage employees to take advantage of the coverage available through HMOs already "bought and paid for" by the university.

The effort included three considered stages:

**Step 1** – A diligent project manager drilled down on exact health plan offerings and created user-friendly communications outlining smoking cessation program options.

**Step 2** – Through various communication media, the benefits department educated employees about their smoking cessation benefits including a mailed flyer that described eligibility criteria and types of

smoking cessation benefits provided by each HMO (Blue Shield, Kaiser, Health Net, and PacifiCare).

**Step 3** – Stanford designed and implemented a supporting incentive that complements the plans' coverage with employer-sponsored assistance for OTC nicotine patches and gum and wellness programs offered through the Stanford School of Medicine Health Improvement Program (HIP).

Linking the intervention to Stanford's unique suite of wellness programs (the above mentioned HIP) into which employees may enroll enhanced the effort. HIP provides three modalities of smoking cessation behavior change support ranging from one-on-one consultation to a three-stage Web-based program. Between plan offerings, HIP offerings, and promotion of the state quit line, Stanford's messaging focuses on the theme of choices and includes careful protection of employee confidentiality as well.

# Lessons Learned and Opportunities for Improvement

The analysis and survey results presented in this report have identified several key gaps and opportunities for improved provision and use of smoking cessation services among privately insured employees in California.

A first step for employers is to understand the extent of smoking behavior among their employee population. To that end, they need to pressure health plans to be more proactive about identification and reporting of smokers among their membership. Much more work is necessary at the health plan level to be able to identify smokers. This includes provider coding education, more reporting and analysis of prescription data usage, and better and more effective utilization of HRA results.

When it comes to changing employees' smoking behavior, California employers are hesitant to use punitive measures. In the area of incentives and rewards for cessation treatment use, more research is needed to determine which approaches are most effective. In general, there is also a need for employers and plans to measure and track program participation, to track quit rates from various programs, and to better understand how to engage consumers in available programming.

A missed opportunity for employers is communication with employees about smoking cessation benefits available through their health plans. The fact that employees enroll in a range of plans complicates employers' ability to effectively target workers with tailored information. However, these challenges are not insurmountable -- employers like Stanford University have effectively and successfully communicated available coverage to their workforce.

Several toolkits are available to support purchaser implementation of smoking cessation programs, including the Public Health Service guideline which has been recently updated along with the A Purchasers' Guide to Clinical Preventive Services: Moving Science into Coverage.<sup>45</sup> Finally, California's culture and commitment to fight tobacco use should not be underestimated. Public policy efforts, reinforced by law, may be the driving force behind the state's lower smoking prevalence -- not employer coverage practices.

Governor Arnold Schwarzenegger declared 2007 the year of health reform, and as part of that effort, several legislative proposals have emerged that focus attention on the need for greater funding of preventive care. The Governor's proposal calls for a state-funded initiative to increase consumer awareness of existing cessation benefits available to California smokers through their public and private providers of health coverage. His proposal would also increase funding for drug therapies available through the California Smokers' Helpline. These efforts, if implemented, may broaden the state's role in addressing tobacco use. Such programs improve the health of the worker applicant pool by reducing the number of smokers in the population as a whole. As such, there may be a natural partnership or public policy role for forward-looking purchasers and health plans interested in addressing tobacco use through population interventions, including community initiatives, promotion of the California Smokers' Helpline, effective allocation of tobacco taxes and enhancements in public smoke-free policies.

# Appendix

## 1. Tobacco Cessation Resources

- General
- Work Place/Worksite Resources
- Community Resources
- Clinical Resources

## 2. 2008 eValue8 California Health Plan Responses

- Health Plan Use of Vendors and Program Availability
- Behavior Change Programs and Coverage
- Prescription and Over-the-Counter Medication Coverage
- Health Plan Identification and Outreach
- Program Measurement and Performance

# Appendix 1. Resources



NATIONAL BUSINESS  
GROUP ON HEALTH  
& CENTERS FOR  
DISEASE CONTROL  
AND PREVENTION



## Centers for Disease Control and Prevention

<http://www.cdc.gov/tobacco/>

This website hosts a multitude of resources for employers, providers, smokers, parents, etc. "Addressing Tobacco in the Workplace: A Resource Guide" will be available on this site in Spring, 2008.

## Institute of Medicine

<http://www.iom.edu/CMS/3793/20076/43179.aspx>

This book outlines proposed strategic approaches for consideration by the health care industry, state and local government, and federal agencies. The "blueprint" describes the multi-dimensional benefits to society when interventions and policies are implemented.

## Partnership for Prevention

<http://www.prevent.org/content/view/28/38/>

This website hosts facts and resources relative to the cost of tobacco use and the cost effectiveness of treatment. The Tobacco Control component of "Investing in Health" will be accessible on this site in early 2008.

## Work Place/Worksite Resources

### A Purchaser's Guide to Clinical Preventive Services: Translating Science into Coverage

<http://www.businessgrouphealth.org/benefitsttopics/topics/purchasers/fullguide.pdf>

Toolkit for employers making benefit design decisions about smoking cessation and other preventative coverage policies

### America's Health Insurance Plans-Online ROI Calculator

[www.businesscaseroi.org](http://www.businesscaseroi.org)

The calculator provides information for determining the cost of not addressing tobacco as well as the cost of initiating a tobacco treatment benefit. It is useful for benefit managers as well as health plan product managers.

### State Building and Construction Trades Council of California Building Trades Unions Ignite Less Tobacco (BUILT) Program

(510) 331-9144

<http://www.sbctc.org/built/>

Website offers comprehensive information regarding smoking cessation for employees including brochures, guides, a quit DVD and an employer tool kit.



## Community Resources

### American Lung Association of California

(510) 638-LUNG

[www.californialung.org](http://www.californialung.org)

Website provides a full range of smoking cessation fact sheets, quit assistance and support services and their book, *Seven Steps to a Smoke Free Life*. Website also provides a link to a free online smoking cessation program, *Freedom From Smoking Online*.



### American Cancer Society, California Division

(916) 448-0500

[www.cancer.org](http://www.cancer.org)

[http://www.cancer.org/downloads/COM/FreshStart\\_Brochure\\_final.pdf](http://www.cancer.org/downloads/COM/FreshStart_Brochure_final.pdf)

Website includes a range of fact sheets, a quit hotline, support advice a smoking cessation guide and a link to their highly successful *Fresh Start* smoking cessation program.



### American Heart Association, California Division

(916) 446-6505

[www.americanheart.org](http://www.americanheart.org)

This website provides information about the link between smoking and cardiovascular disease. It links to [smokefree.gov](http://smokefree.gov) as a resource to support consumers' smoking cessation. Additionally, there are worksheets available to address common smoking cessation issues relevant to stress and weight gain, and includes overview information about what to expect through out the smoking cessation process.



### National Cancer Institute's "Smokefree.gov"

[www.smokefree.gov/resources.html](http://www.smokefree.gov/resources.html)

Website includes a wide array of fact sheets and a multitude of guides, booklets and other resources to help individuals stop smoking and stay quit.



### Campaign for Tobacco Free Kids

[www.tobaccofreekids.org](http://www.tobaccofreekids.org)

Website provides resources and research on tobacco use and cessation strategies targeted at children and young adults.



### Asian & Pacific Islander American Health Forum

#### Asian Pacific Islander Tobacco Education Network

(415) 954-9988

<http://www.apiahf.org/programs/apiten/index.htm>

Website provides background and resources for smoking cessation including telephone counseling lines in various languages. The Asian Pacific Islander American Health Forum offers a complete list of health provider resources that the API population can access for smoking cessation services. Please call APIAHF to obtain health provider list.



**California Black Health Network  
African American Tobacco Education Partnership**

(916) 448-7900

[www.cbhn.org/aaten.html](http://www.cbhn.org/aaten.html)

Website provides a variety of information regarding smoking cessation and the African American community including events, fact sheets, resources and support service links.



**National African American Tobacco Education Network**

(916) 556-3344

<http://www.naaten.org/resource.html>

This website link provides information to educate and empower the African American/Black community against tobacco use. A 1-1/2 hour educational training is offered in a CD format.

**Clinical Resources**

**Department of Health and Human Services: Office of the Surgeon General**

[http://www.surgeongeneral.gov/tobacco/treating\\_tobacco\\_use08.pdf](http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf)

See "Treating Tobacco Use and Dependence: 2008 Update" by the US Public Health Service.

<http://www.surgeongeneral.gov/library/secondhandsmoke/>

See "The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General." This comprehensive report provides the scientific evidence indicating no amount of second hand smoke exposure is without risk.

**Department of Health and Human Services: Agency for Healthcare Research and Quality**

<http://www.ahrq.gov/clinic/tobacco/>

See above, "Treating Tobacco Use and Dependence" the Public Health Service clinical practice guideline.



## Appendix 2: 2008 eValue8 California Health Plan Responses

Data shown here are extracted from the 2008 eValue8 health plan RFI, supplemented in some cases by health plan interviews. Original data are self-reported and then verified through the eValue8 Health Plan RFI scoring process. Health plans were subsequently given opportunity to comment or correct submissions. Specific questions about data here may be directed to the health plan directly.

<b>Health Plan Use of Vendors and Program Availability<sup>1</sup></b>	
<b>Aetna PPO</b>	Healthroads, a division of American Specialty Health. Employer option to purchase.
<b>Anthem Blue Cross PPO</b>	"Tobacco-Free," a Healthy Lifestyles standalone program for tobacco cessation through Healthways.
<b>CIGNA PPO</b>	Administered by CIGNA Behavioral Health (Care Allies), called "Quit Today". It is available to all CIGNA BH capitated clients and as a buy-up to others.
<b>Health Net HMO</b>	WebMD for web based program and Health Dialog for telephonic program
<b>Kaiser North HMO</b>	California Smokers' Helpline for telephonic counseling. Online program is HealthMedia. All programs are available to members as often as needed with no copay.
<b>Kaiser South HMO</b>	Online program is HealthMedia.
<b>PacifiCare (UnitedHealthcare HMO)</b>	Free & Clear Stop Smoking. Available to all commercial members for \$20 per year.
<b>UnitedHealthcare PPO</b>	QuitPower program. Employer option to purchase.

<sup>1</sup>Blue Shield of California did not participate in the 2008 eValue8 Health Plan assessment.

<b>Behavior Change Programs and Coverage</b>				
	<b>Group Sessions</b>	<b>Individual in-person counseling</b>	<b>Telephonic Counseling</b>	<b>Online Support</b>
<b>Aetna PPO</b>	Educational workshops displays available through Summit Health Workplace Wellness program as an employer buy-up.	No, unless addressed by a behavioral health practitioner through the mental health benefit.	Available as buy up option for employers.	Available to all commercial members.
<b>Anthem Blue Cross PPO</b>	Through the Tobacco-Free program, group sessions are provided through QuitNet.	No, unless addressed by a behavioral health practitioner through the mental health benefit.	Through the Tobacco-Free program. May receive 5 outbound calls and place unlimited calls over 12 months.	Through the Tobacco-Free program, 24/7 online support is provided through Quit Net.
<b>CIGNA PPO</b>	No, unless addressed by a behavioral health practitioner through the mental health benefit.	No, unless addressed by a behavioral health practitioner through the mental health benefit.	Part of Quit Today, 4-7 sessions based on stratified need. Then, 30-day, 6-month, 12-month follow up calls post-graduation from program.	Part of Quit Today, as alternative to or in addition to telephonic counseling. Contains 8 topical modules with structured email delivery over time.
<b>Health Net HMO</b>	Might be available through provider group	No, unless addressed by a behavioral health practitioner through the mental health benefit.	Decision Power telephonic program. Toolkit mailed out, 24/7 access to Health Coach, followup to assess status at 6/12 months using email and automated call with warm transfer to Health Coach.	10-step online program through WebMD accessible by the member at <a href="http://www.healthnet.com">www.healthnet.com</a> select Wellsite and Health Dialog (Dialog Center); available to all commercial members.
<b>Kaiser North HMO</b>	At facility level. Typically offers both a single session for 3-4 hours and a 6-10 week option.	Through health educator.	Through California Smokers' HelpLine	Health Media available to all commercial members.
<b>Kaiser South HMO</b>	At facility level. Offers 5-10 multi-session group program.	No (rare exceptions for special circumstances.)	Internal program: assessment, referral and counseling. Usually 2-3 calls outbound. Inbound calls unlimited.	Health Media available to all commercial members.
<b>PacifiCare (UnitedHealth-care HMO)</b>	Not offered.	No, unless addressed by a behavioral health practitioner through the mental health benefit.	Participants assigned to a smoking cessation specialist and receive five to six calls over a one-year period.	Interactive program on <a href="http://www.pacificare.com">www.pacificare.com</a> and HealthCredits may be applied.
<b>UnitedHealth-care PPO</b>	Not offered	No, unless addressed by a behavioral health practitioner through the mental health benefit.	Available through the QuitPower program, available as an employer buy-up.	Interactive online support available to all members.

Prescription and Over-the-Counter Medication Coverage						
	Coverage rules	Zyban <sup>®</sup>	Bupropion/ generic Zyban <sup>®</sup>	Chantix <sup>®</sup>	NRT inhalers/ nasal sprays	OTC NRT and Other Products
<b>Aetna PPO</b>	At discretion of employer.	At discretion of employer.	At discretion of employer.	At discretion of employer.	At discretion of employer.	6 weeks of OTC NRT is included in Healthyroads program. Additional coverage at the discretion of employer.
<b>Anthem Blue Cross PPO</b>	At discretion of employer.	Optional buy-up.	At discretion of employer.	At discretion of employer.		OTC NRT provided via NextRx.
<b>CIGNA PPO</b>	At discretion of employer.	Buy up coverage optional for employer distinct from Quit Today buy-up.	Yes	Buy up coverage optional for employer distinct from Quit Today buy-up.	Buy up coverage optional for employer distinct from Quit Today buy-up.	Included for members who participate in Quit Today, at no member cost.
<b>Health Net HMO</b>	All prescriptions are allowed only with participation in a behavior modification program, validated by prescribing physician. Does not have to be a HN program.	50%	50%	50%	50% (nasal spray only).	No discount.
<b>Kaiser North HMO</b>	All prescriptions at drug copay only with validated participation in a Kaiser program. No limit on number of courses of therapy/yr, if clinically indicated.	Only after generic fails and at brand copay.	Yes	Yes, at brand copay and as a Step 2 alternative.	Yes, as a Step 2 alternative.	Yes, at copay amount.
<b>Kaiser South HMO</b>	All prescriptions at drug copay. Participation in behavior change program is required.	Only after generic fails and at brand copay.	Yes	Yes, at brand copay and as a Step 2 alternative.	Yes, as a Step 2 alternative.	Yes, at copay amount.
<b>PacifiCare (United-Healthcare HMO)</b>	Prescription for Zyban <sup>®</sup> covered at \$20 copay with verified enrollment in PacifiCare Free & Clear program.	\$20 copay. Must be enrolled in Free & Clear program.	Yes, \$20 copay.	Excluded.	Excluded.	20% discount for QuitKey.
<b>United-Healthcare PPO</b>	While prescription medication is not included, full coverage for over-the-counter nicotine replacement therapy (patches, gum) is included with QuitPower.	Excluded through QuitPower; may be available through employer's pharmacy benefit.	Excluded through QuitPower; may be available through employer's pharmacy benefit.	Excluded through QuitPower; may be available through employer's pharmacy benefit.	Excluded.	Eight weeks of over-the-counter nicotine replacement therapy, including patches and gum, through QuitPower.

Health Plan Identification and Outreach					
	Smoker Identification and Outreach	% of Members Identified	% Engaged in Program	High Risk Populations Targeted	Provider Outreach
<b>Aetna PPO</b>	Self referral, Health Risk Assessment, surveys for maternity & Healthy Weight program participants, Telephone case/disease mgmt assessment (with access to benefits to assure referral to covered program).	17% reported by Plan. 7.4% of members are identified using CAHPS data sample.	Not reported.	Pregnancy, post-cardiac event, diabetes, asthma, disease management program participants, Aetna Healthy Body & Healthy Weight Program participants.	General education, member information for distribution.
<b>Anthem Blue Cross PPO</b>	Self referral, Health risk assessment, survey or intake from disease mgmt programs.	Not tracked by Plan; 6.86% of members are identified using CAHPS data sample.	Not reported.	Pregnancy, postpartum recidivism; post-cardiac event, diabetes, asthma through disease management programs.	No practitioner education or activities.
<b>CIGNA PPO</b>	PCP referral, Self referral, Health risk assessment, program-specific surveys for disease management participants and health line referrals.	0.06% reported by Plan; CAHPS data not available.	100% of identified smokers (0.06% of membership).	Pregnancy, depression, inpatient and case management.	General education, patient specific notices upon program enrollment, incentives for appropriate use of smoking-related diagnosis codes.
<b>Health Net HMO</b>	PCP referral, Self referral, HRA, electronic medical record, all health coaching/disease management sessions.	Not tracked by Plan; 14.81% of members are identified using CAHPS data sample.	0.11% of commercial membership.	Post-cardiac event, diabetes, asthma, second hand smoke, all disease management programs.	General education.
<b>Kaiser North HMO</b>	PCP referral, self referral, HRA, smoking status checked as a vital sign, all disease management programs, electronic medical records.	6.5% of members reported by Plan; 14.81% of members are identified using CAHPS data sample.	5.0% of identified smokers.	All	General and CME-credited education, reports on comparative performance and member smoking status, incentives to screen and treat
<b>Kaiser South HMO</b>	PCP referral, self referral, HRA, smoking status checked as a vital sign is currently being implemented, all disease management programs, electronic medical records.	0.08% of members reported by Plan; 11.05% of members are identified using CAHPS data sample.	100% of identified smokers (0.08% of membership).	Pregnancy, post-cardiac event, Inpatient efforts.	General and CME-credited education, reports on comparative performance and member smoking status, incentives to screen and treat. Inpatient discharge and cardiac follow-up care forms include smoking assessments and cessation advice.
<b>Pacificare (United-Healthcare HMO)</b>	PCP referral, Self referral, Health risk assessment.	7% of members reported by Plan; 9.3% of members are identified through CAHPS data sample.	0.3% of commercial population.	Pregnancy, post-cardiac event, diabetes, asthma, second hand smoke exposure reduction.	General education
<b>United-Healthcare PPO</b>	Self referral, HRA, other disease management programs.	0.3% of members reported by Plan; 4.7% of members are identified through CAHPS data sample.	3.5% of identified smokers	Pregnancy, adolescents, second hand smoke exposure.	No practitioner education or activities.

Program Measurement and Performance				
	2007 HEDIS Advising Smokers to Quit <sup>1</sup>	2007 CAHPS Discussing Medications <sup>2</sup>	2007 CAHPS Discussing Cessation Strategies <sup>3</sup>	Quit Rates (Self-Reported)
<b>Aetna PPO</b>	Not measured	Not measured	Not measured	Not measured
<b>Anthem Blue Cross PPO</b>	64.4%	40.5%	43.2%	Not tracked
<b>CIGNA PPO</b>	Not measured	Not measured	Not measured	6 month 85.7% of program participants reached
<b>Health Net HMO</b>	58.0%	34.1%	35.2%	Not tracked
<b>Kaiser North HMO</b>	83%	51%	58%	6 month 54% 12 month 40% Plan follow-up assuming all non-responders are still smoking. Kaiser North also tracks outcome by treatment modality.
<b>Kaiser South HMO</b>	66%	37%	41%	6 month 54%
<b>PacifiCare (United-Healthcare HMO)</b>	68.7%	34.9%	32.9%	35.8%
<b>UnitedHealthcare PPO</b>	60%	33%	32.9%	Not measured
<b>National Comparison Benchmarks (90th, 75th, 50th and 25th percentiles)</b>	80.2% 77.6% 74.0% 70.8%	53.0% 49.6% 43.8% 38.5%	52.8% 48.6% 42.5% 38.3%	

<sup>1</sup>Advising Smokers to Quit: the percentage who received advice to quit smoking from their practitioner. In general, the percentage of survey respondents who indicated they smoked was approximately 10-11 percent.

<sup>2</sup>Discussing Smoking Cessation Medications: the percentage whose practitioner discussed smoking cessation medications.

<sup>3</sup>Discussing Smoking Cessation Strategies: the percentage whose practitioner discussed smoking cessation methods or strategies.

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