## SENATE HEARING SLIP

(Please Print Plainly)

DATE: July 29, 1999

BILL NO. Senate Bill 115

or

SUBJECT

James Tenuta

(NAME)

16 North Carroll, Suite 800

(Street Address or Route Number)

Madison, WI 53703

(City and Zip Code)

Wisconsin Association of Life and Health Insurers

(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☒

Speaking for information only; Neither for nor against: ☐

Please return this slip to a messenger PROMPTLY.

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State Capitol - B35 South
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Madison, WI 53707-7882

## SENATE HEARING SLIP

(Please Print Plainly)

DATE: July 29-99

BILL NO. SB 115

or

SUBJECT

ERIC BORGERDING

(NAME)

501 E. WASHINGTON AVE

(Street Address or Route Number)

MADISON, WI 53703

(City and Zip Code)

WI Mfgs. & Commerce

(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☒

Speaking for information only; Neither for nor against: ☐

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## SENATE HEARING SLIP

(Please Print Plainly)

DATE: July 29, 1999

BILL NO. SB 115

or

SUBJECT

Bill Smith

(NAME)

1 North Pinckney Suite 201

(Street Address or Route Number)

Madison

(City and Zip Code)

NFIB

(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☒

Speaking for information only; Neither for nor against: ☐

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## SENATE HEARING SLIP

(Please Print Plainly)

DATE: July 29, 1999

BILL NO. SB 115

or

SUBJECT

Edward Blume

(NAME)

6441 Enterprise Lane

(Street Address or Route Number)

Madison, WI 53719-5018

(City and Zip Code)

Wisconsin Assoc of Health Underwriters

(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☒

Speaking for information only; Neither for nor against: ☐

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## SENATE HEARING SLIP

(Please Print Plainly)

DATE: 29 July 1999

BILL NO. SB115

or

SUBJECT

M. Colleen Wilson

(NAME)

330 E Lakeside St.

(Street Address or Route Number)

Madison 53715

(City and Zip Code)

State Medical Society

(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor: but not speaking: ☑

Registering Against: but not speaking: ☐

Speaking for information only; Neither for nor against: ☐

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## SENATE HEARING SLIP (2)

(Please Print Plainly)

DATE: 7/29/99

BILL NO. SB 115

or

SUBJECT

Ask to Appear

Michael Fiedler MD

(NAME)

(Street Address or Route Number)

(City and Zip Code)

(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☐

Speaking for information only; Neither for nor against: ☒

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## SENATE HEARING SLIP (4)

(Please Print Plainly)

DATE: July 29, 1999

BILL NO. Senate Bill 115

or

SUBJECT

Gary Radloff

(NAME)

2 E Mifflin St

(Street Address or Route Number)

Madison, WI 53703

(City and Zip Code)

Association of Wisconsin HMOs

(Representing)

Speaking in Favor: ☐

Speaking Against: ☒

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☐

Speaking for information only; Neither for nor against: ☐

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## SENATE HEARING SLIP (3)

(Please Print Plainly)

DATE: 7/29

BILL NO. SB115

or

SUBJECT Coverage of Smoking Cessation Treatment

Katheen Knavel

(NAME)

Appearing For Rep. Black

(Street Address or Route Number)

(City and Zip Code)

Rep. Spencer Black

(Representing)

Speaking in Favor: ☒

Speaking Against: ☐

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☐

Speaking for information only; Neither for nor against: ☐

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## SENATE HEARING SLIP (1)

(Please Print Plainly)

DATE: 7/29/99

BILL NO. SB115

or

SUBJECT Insurance Coverage of smoking cessation

Sen Judy Robson

(NAME)

SD-15

(Street Address or Route Number)

Beloit WI 53511

(City and Zip Code)

(Representing)

Speaking in Favor: ☒

Speaking Against: ☐

Registering in Favor: but not speaking: ☐

Registering Against: but not speaking: ☐

Speaking for information only; Neither for nor against: ☐

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Madison, WI 53707-7882

## SENATE HEARING SLIP 15

(Please Print Plainly)

DATE: 7/29/99

BILL NO. SB 115
or
SUBJECT

David Ahrens
(NAME)

(Street Address or Route Number)

(City and Zip Code)

Tobacco Free Wisconsin
(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor:
but not speaking: ☐

Registering Against:
but not speaking: ☐

Speaking for information
only; Neither for nor against: ☒

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P.O.Box 7882
Madison, WI 53707-7882

## SENATE HEARING SLIP 16

(Please Print Plainly)

DATE: July 29, 1999

BILL NO. SB 115
or
SUBJECT Smoking Cessation

Sarah Bowen
(NAME)

121 South Hancock Street
(Street Address or Route Number)

Madison WI 53703
(City and Zip Code)

WI Society of Clinical & Consulting Psychologists
(Representing)

Speaking in Favor: ☐

Speaking Against: ☐

Registering in Favor:
but not speaking: ☐

Registering Against:
but not speaking: ☐

Speaking for information
only; Neither for nor against: ☒

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State Capitol - B35 South
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Madison, WI 53707-7882

## SENATE HEARING SLIP 7

(Please Print Plainly)

DATE: 7/29/99

BILL NO. 115
or
SUBJECT

Katie Sullivan Paul
(NAME)

4912 Wakanda Dr.
(Street Address or Route Number)

Wauwatosa WI 53597
(City and Zip Code)

Tobacco Free Dane County Coalition
(Representing)

Speaking in Favor: ☒

Speaking Against: ☐

Registering in Favor:
but not speaking: ☐

Registering Against:
but not speaking: ☐

Speaking for information
only; Neither for nor against: ☐

Please return this slip to a messenger PROMPTLY.
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State Capitol - B35 South
P.O.Box 7882
Madison, WI 53707-7882

# Vote Record

## Senate - Committee on Human Services and Aging

Date: 9/23/99

Bill Number: SB 115

Moved by: Wirch  Seconded by: Rosenzweig

Motion: passage as amended

| Committee Member | Aye | No | Absent | Not Voting |
|---|---|---|---|---|
| Sen. Judy Robson, Chair | ☑ | ☐ | ☐ | ☐ |
| Sen. Gwendolynne Moore | ☑ | ☐ | ☐ | ☐ |
| Sen. Robert Wirch | ☑ | ☐ | ☐ | ☐ |
| Sen. Carol Roessler | ☑ | ☐ | ☐ | ☐ |
| Sen. Peggy Rosenzweig | ☑ | ☐ | ☐ | ☐ |
| Totals: | 5 | | | |

☒ Motion Carried  ☐ Motion Failed

# Vote Record

## Senate - Committee on Human Services and Aging

Date: 9/23/99
Moved by: ~~[illegible]~~ Wirch
Seconded by: Rosenzweig
Clearinghouse Rule:
Appointment:
Other:

AB: SB:
AJR: SJR:
AR: SR:

A/S Amdt:
A/S Amdt: to A/S Amdt:
A/S Sub Amdt:
A/S Amdt: to A/S Sub Amdt:
A/S Amdt: to A/S Amdt: to A/S Sub Amdt:

Be recommended for:

- ☐ Passage
- ☒ Introduction - by unanimous consent
- ☒ Adoption
- ☐ Rejection
- ☐ Indefinite Postponement
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence
- ☐ Confirmation

| Committee Member | Aye | No | Absent | Not Voting |
|---|---|---|---|---|
| Sen. Judy Robson, Chair | ☑ | ☐ | ☐ | ☐ |
| Sen. Gwendolynne Moore | ☐ | ☑ | ☐ | ☐ |
| Sen. Robert Wirch | ☑ | ☐ | ☐ | ☐ |
| Sen. Carol Roessler | ☑ | ☐ | ☐ | ☐ |
| Sen. Peggy Rosenzweig | ☑ | ☐ | ☐ | ☐ |
| Totals: | 4 | 1 | | |

LRBa0628/1

☒ Motion Carried ☐ Motion Failed

# Vote Record

## Senate - Committee on Human Services and Aging

Date: 9/23/99
Moved by: Wirch
Seconded by: Rosen
Clearinghouse Rule:
AB: SB:
AJR: SJR:
AR: SR:
Appointment:
Other:

A/S Amdt:
A/S Amdt: to A/S Amdt:
A/S Sub Amdt:
A/S Amdt: to A/S Sub Amdt:
A/S Amdt: to A/S Amdt: to A/S Sub Amdt:

Be recommended for:

- [ ] Passage
- [x] Introduction – by unanimous consent
- [x] Adoption
- [ ] Rejection
- [ ] Indefinite Postponement
- [ ] Tabling
- [ ] Concurrence
- [ ] Nonconcurrence
- [ ] Confirmation

| Committee Member | Aye | No | Absent | Not Voting |
|---|---|---|---|---|
| Sen. Judy Robson, Chair | ✓ | | | |
| Sen. Gwendolynne Moore | | ✓ | | |
| Sen. Robert Wirch | ✓ | | | |
| Sen. Carol Roessler | ✓ | | | |
| Sen. Peggy Rosenzweig | ✓ | | | |
| Totals: | 4 | 1 | | |

LRB a0630/1

- [x] Motion Carried
- [ ] Motion Failed

Judith B. Robson
Wisconsin State Senator

September 27, 1999

Mr. Ira Sharenow
4817 Sheboygan Ave., #617
Madison, WI 53705

Dear Mr. Sharenow:

Enclosed please find the following material that you requested regarding the meeting of the Senate Committee on Human Services and Aging:

1. Hearing slips for SB 22;
2. Written materials submitted by David Remes, a representative of the tobacco companies, who testified against SB 22;
3. Hearing slips for SB 144;
4. Written testimony regarding SB 144 from persons registering as representatives of Wisconsin State Employees Local 1;
5. Two simple amendments to SB 115; and
6. A substitute amendment to SB 122.

Regarding your other requests:

The document referred to in SB 115 (Clinical Practice Guideline, No. 18, Smoking Cessation, published by the U.S. Department of Health and Family Services) is more than 125 pages. If you would like to inspect this document in our office, please make an appointment to do so.

You asked whether a number of treatments such as herb teas, natural medicine, massage, etc. would be included under SB 115. These treatments are not specified in SB 115, so it is my understanding that coverage for these treatments would not be required.

You also asked how much money coverage might cost and asked for an itemized list of costs for doctors' fees, medicine, lab tests and other costs. You also asked for averages, medians and a standard range that covers 99% of the cases in which a person chooses a method that requires payment of a fee.

15 South, State Capitol, Post Office Box 7882, Madison, WI 53707-7882 • Telephone (608) 266-2253
District Address: 2411 East Ridge Road, Beloit, WI 53511
Toll-free 1-800-334-1468 • E-Mail: sen.robson@legis.state.wi.us

SB 115

1. Sen Robson - Senate author

2. Dr Fiore, UW Medical School

Four points:

1) Toll on WI
   25% adults smoke (1 million)
   ≈ 8,000 killed by tobacco
   leading cause of preventable death
   $1.4 billion in annual costs
   $270 per resident
   Expensive for employers $1000 per year per smoking employee

2) 8/10 of smokers want to quit
   Drug is highly addictive as heroine + cocaine
   80% have tried once and failed
   Not a bad habit, but a chronic disease,

3) Insurance companies exclude smoking counseling
   Evidence-based research are available
   No treatment now available that is as effective in savings per life and per $

4) Bill is so important because:
   Cost is very high to get treatment out of pocket
   But nowhere near the cost of a $15,000-$20,000 surgery

Won't be abased - treatment only available once per year

May want to strengthen language by limiting drugs that are FDA approved.

1 utility per year, once in a lifetime

Robson: Cost?

Fiore: $167-300 per drug treatment, maybe another $200 for counseling
$1200 is very high.

Robson: Will this drive up costs?

Fiore: $100 (patch) to $300 for nonhalers a month
Zyban $250 for 3 months
Up to 3 counseling visit $150 total.
Other health professionals could do this

$1200 is a lot and more than you need.

Reesler: What is involved in counseling

Fiore: Set a quit date, ask them what works for them
Alcohol counseling, social pressures, what happened
in the past when they tried to quit

~~[illegible]~~

☆ 3. Kathleen ~~[illegible]~~ Knavel of Spencer Black's office speaking f

☆ 4. Gary Radloff, Assoc. of WI HMO's speaking against
Oppose because the tobacco money is there
& because it is a mandate
Not sold that the products work
People still fail on this program
This will hurt the poor because it will raise costs

5. David Ahrens, Tobacco Free WI for info only
In states where prevention commercials run people went to quit.
We have to have a mechanism so that we can do that

6. Sarah Bowen, WI Society of Clinical & Consulting Psychologists for info

1) Is hypnosis covered, why not if not?
They would like to offer other guidelines

Other treatments may work as well

2) What is the role of psychologist here?

Medical mandate vs mental health mandate

7. Katie Sullivan Paul, Tobacco Free Dane County — spkg in favor

Public Health Nurse

Thinks HMO logic is addressable

Public Health Agencies cannot take the capacity of this service

**Fact Sheets**

## Tobacco Prevention Saves Lives - and Money

More than 87% of likely Wisconsin voters want at least half of Wisconsin's share of the national tobacco settlement used to reduce smoking among kids, an October, 1998 poll found. The statewide survey found that more voters favor spending settlement money for tobacco prevention rather than other spending options, including tax relief.

### Tobacco Costs Wisconsin Taxpayers Big Money Every Year:

- **$1.37 Billion:** Annual cost to Wisconsin residents for direct health expenditures due to smoking. Not included: costs due to other tobacco uses, second-hand smoke, prenatal smoke exposure, and injuries due to fires caused by cigarettes.
- **$267** Annual costs per Wisconsin resident for direct health care costs related to treating sick smokers.
- **$620 Million:** State & Federal tax burden from tobacco-caused health costs.
- **$190 Million:** Yearly state Medicaid payments for treating sick smokers.
- **$310** Annual cost per Wisconsin household for the state and federal tax burden from tobacco-related health expenses.
- **$1,000** How much more it costs on average to insure an employee who smokes.

### *Real Tax Relief*

Currently, Wisconsin smoking rates are higher than the national average: 37 percent of young people smoke; 40 percent of pregnant women smoke. As these numbers increase, so will the associated costs. The only way to protect Wisconsin taxpayers from these costs in years to come is to reduce tobacco use by investing in comprehensive tobacco prevention programs.

- **50 cents:** What Wisconsin currently spends annually on tobacco prevention per capita. Tobacco is the states singlemost preventable cause of premature death and disability. It kills more people than HIV/AIDS, illicit drug use, murder, suicide, homicide and accidents combined.
- **$6.03 to $15.66** Annual per capita cost to implement comprehensive tobacco prevention efforts in Wisconsin, according to The Centers for Disease Control and Prevention.

*Previous*

SMOKING CESSATION INTERVENTIONS OFFER THE GREATEST OPPORTUNITY TO IMPROVE THE CURRENT AND FUTURE HEALTH OF WISCONSIN RESIDENTS. IT IS ESSENTIAL THAT WE TAKE AN ACTIVE ROLE IN REDUCINT THE PREVALENCE OF TOBACCO USE. ONE WAY TO DO THIS IS THROUGH THE SUPPORT AND DELIBERY OF EFFECTIVE SMOKING CESSATION INTERVENTIONS.

ONE OF THE BARRIERS TO EFFECTIVE SMOKING CESSATION TREATMENTS IS COST AND INSUFFICIENT INSURANCE REIMBURSEMENTS INSURANCE COVERAGE HAS BEEN SHOWN TO INCREASE THE RATES OF CESSATION SERVICES UTILIZATION AND THEREFORE INCREASE RATES OF QUITTING.

RECENTLY AN 8 YEAR INSURANCE INDUSTRY STUDY FOUND THAT REIMBURSING PHYSICIANS FOR PROVIDING PREVENTIVE CARE RESULTED IN REPORTED INCREASES IN EXERCISE, SEAT BELT USE, WEIGHT LOSS AND DECREASED ALCOHOL USE. SO REIMBURSEMENT FOR PREVENTION CARE HAS POSITIVE OUTCOMES.

SMOKING CESSATION TREATMENTS SHOULD BE PROVIDES FOR SUBSCRIBERS OF HEALTH INSURANCE/MANAGED CARE.

**Fact Sheets**

# The Toll of Tobacco in Wisconsin

Tobacco Use in Wisconsin

- High school students who smoke: 36%
- High school males who use smokeless tobacco: 19%
- Number of kids (under 18) who become new daily smokers each year: 26,000
- Kids exposed to second hand smoke at home: 428,000
- Number of packs of cigarettes illegally sold to kids in Wisconsin each year: 5.3 million
- Adults in Wisconsin who smoke: 23%

While adult smoking has generally been decreasing throughout the country in recent years, these declines have slowed or stopped. In contrast, smoking among kids increased steadily throughout much of the 1990s. Although national underage smoking rates finally dropped slightly from 1997 to 1998, they remain at historically high levels. Over the past ten years, the number of kids under 18 in the U.S. who become new daily smokers each year has risen by more than 70 percent.

Deaths in Wisconsin From Smoking

- Number of people who die each year in Wisconsin from smoking: 7,800
- Wisconsin kids alive today who will eventually die from smoking: 117,000 (if current trends continue)

Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined -- and thousands more die from other tobacco-related causes -- such as fires caused by smoking (more than 1,000 deaths/year nationwide), exposure to second hand smoke (more than 40,000 deaths), and smokeless tobacco use. No good estimates are currently available, however, for the number of Wisconsin citizens who die from these other tobacco-related causes, or for the much larger numbers who suffer from tobacco-related health problems each year without actually dying.

Tobacco-Related Monetary Costs

- Annual health care expenditures in Wisconsin directly related to smoking: $1.3 billion
- Yearly Wisconsin government Medicaid payments directly related to smoking: $190 million
- Additional annual expenditures in Wisconsin for babies' health problems caused by mothers smoking or being exposed to second hand smoke during pregnancy: $38 to $109 million

**Additional health care expenditures caused by tobacco include the costs related to direct exposure to second hand smoke, smoking-caused fires, and smokeless tobacco use. Although these additional health expenditures certainly total in the tens of millions of dollars in Wisconsin, and increase the Wisconsin government's Medicaid burden, there are no good state estimates currently available. Other non-health costs caused by tobacco use include direct residential and commercial property losses from fires caused by cigarettes or cigars (more than $500 million nationwide); work productivity losses from work absences, on-the-job performance declines, and early termination of employment caused by tobacco-related health problems ($40+ billion per year nationwide); and the costs of the extra cleaning and maintenance made necessary by tobacco smoke, smokeless tobacco spit, and tobacco-related litter (about $4+ billion per year nationwide for commercial establishments alone). No good state-specific estimates of these non-health costs from tobacco are available, but Wisconsin's pro-rata share, based on its population, is at least $860 million per year.**

Tobacco Industry Advertising and Other Product Promotion

- Annual tobacco industry advertising and promotional expenditures nationwide: $5.2 billion
- Estimated portion spent in Wisconsin each year: $100 million

**Published research studies have found that kids are three times more sensitive to tobacco advertising than adults and are more likely to be influenced to smoke by cigarette marketing than by peer**

pressure, and that one-third of underage experimentation with smoking is attributable to tobacco company advertising.

SOURCES

For state-specific data on deaths caused by smoking, smoking and smokeless tobacco use rates, and other tobacco-related information, see Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, State Tobacco Control Highlights 1997 (1998) or see CDC's state-specific website pages [http://www.cdc.gov/nccdphp/osh/statehi/statehi.htm]. See also, CDC, "State-Specific Prevalence Among Adults of Current Cigarette Smoking and Smokeless Tobacco Use and Per Capital Tax-Paid Sales of Cigarettes – United States, 1997," Morbidity and Mortality Weekly Report (MMWR) 47(43): 922-926 (November 6, 1998); CDC, Surveillance Summaries, "Youth Risk Behavior Surveillance – United States, 1997," 47(SS-3): 10-12,15-17, 50-54 (August 14, 1998); CDC, "State-Specific Prevalence of Cigarette Smoking Among Adults, and Children's and Adolescents' Exposure to Environmental Tobacco Smoke – United States, 1996," MMWR 46(44): 1038-1043 (November 7, 1997); CDC, "Smoking Attributable Mortality and Years of Potential Life Lost – United States, 1984" [with editor's update for 1990-1994], MMWR 46(20): 444-451 (May 23, 1997); J. R. Hall, Jr., National Fire Protection Association, The U.S. Smoking-Material Fire Problem Through 1995 (September 1997). For projected smoking deaths among today's youth, see CDC, "Projected Smoking-Related Deaths Among Youth -- United States," MMWR 45(44): 971-974 (November 8, 1996). New underage daily smoker estimate based on data from CDC, "Projected Smoking-Related Deaths" (see above) and CDC, "Incidence of Initiation of Cigarette Smoking – United States, 1965-1996)," MMWR 47 (39): 837-40 (October 9, 1998).

For data on kids exposed to second hand smoke, see CDC, "State-Specific Prevalence of Cigarette Smoking Among Adults, and Children's and Adolescents' Exposure to Environmental Tobacco Smoke – United States, 1996," MMWR 46(44): 1038-1043 (November 7, 1997). State-specific data is not currently available regarding adult exposure to second hand smoke at their homes, or to the numbers exposed to ETS at workplaces, daycare centers, restaurants, or other public facilities.

For data on number of packs of cigarettes illegally sold to kids, see Cummings, et al., "The Illegal Sale of Cigarettes to US Minors: Estimates by State," American Journal of Public Health 84(2): 300-302 (February 1994). See also, CDC, "Tobacco Use and Usual Source of Cigarettes Among High School Students – United States, 1995," MMWR 45(20): 413-418 (May 24, 1996).

For nationwide data on smoking trends see CDC, "Tobacco Use Among High School Students – United States, 1997," MMWR 447(12): 229-233 (April 3, 1998); Institute for Social Research, University of Michigan, Monitoring the Future Study, [http://www.isr.umich.edu/src/mtf/index.html]; CDC, "Incidence of Initiation of Cigarette Smoking – United States, 1965-1996," MMWR 47(39): 837-40 (October 9, 1998).

For state-specific data on smoking-related health expenditures and smoking-related Medicaid expenditures, see L. Miller, et al., "State Estimates of Total Medical Expenditures Attributable to Cigarette Smoking, 1993," Public Health Reports 113: 447-58 (September/October 1998). See also, L. Miller, et al., "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993," Public Health Reports 113: 140-151 (March/April 1998).

For data on costs associated with smoking or exposure to second hand smoke during pregnancy, see E.K. Adams and C.L. Melvin, "Costs of Maternal Conditions Attributable to Smoking During Pregnancy," American Journal of Preventive Medicine 15(3): 212-19 (October 1998); CDC, "Medical Care Expenditures Attributable to Cigarette Smoking During Pregnancy," MMWR 46(44) (November 7, 1997); U.S. Department of the Treasury, The Economic Costs of Smoking in the U.S. and the Benefits of Comprehensive Tobacco Legislation (March 1998); J.J. Stoddard and B. Gray, "Maternal Smoking and Medical Expenditures for Childhood Respiratory Illness," American Journal of Public Health 87(2): 205-209 (February 1997); E. Dejin-Karlsson, et al., "Does Passive Smoking in Early Pregnancy Increase the Risk of Small-for-Gestational-Age Infants?" American Journal of Public Health 88(10): 1523-1527 (October 1998). State expenditures based on its pro rata share of the national estimates, with the pro rata calculations based on the state's portion of the nationwide population of kids exposed to second hand smoke.

For additional information on tobacco-related costs, see U.S. Department of the Treasury, The Economic Costs of Smoking in the U.S. and the Benefits of Comprehensive Tobacco Legislation (1998) [http://www.treas.gov/press/releases/docs/tobacco.pdf]; F.J. Chaloupka and K.E. Warner, "The Economics of Smoking," in J. Newhouse and A. Culyer (eds), The Handbook of Health Economics (in press); CDC, MMWR 46(44) (November 7, 1997); CDC, Making Your Workplace Smokefree: A Decision Maker's Guide (1996); D. Mudarri, The Costs and Benefits of Smoking Restrictions: An Assessment of

the Smoke-Free Environment Act of 1993 (H.R. 3434), U.S. Environmental Protection Agency report submitted to the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives (April 1994); P. Brigham and A. McGuire, "Progress Toward a Fire-Safe Cigarette," Journal of Public Health Policy 16(4): 433-439 (1995); J.R. Hall, Jr., National Fire Protection Association, The U.S. Smoking-Material Fire Problem Through 1995 (September 1997).

For data on tobacco industry advertising, see Federal Trade Commission (FTC), Report to Congress for 1996 Pursuant to the Federal Cigarette Labeling and Advertising Act (1998) [data for top five manufacturers' cigarette marketing only]; FTC, 1997 Smokeless Tobacco Report (1997) [1995 data from top five smokeless tobacco product manufacturers]. The state total is a prorated estimate based on its population compared to that of the entire country. Actual figures for 1998 are likely to be larger.

The referenced studies on cigarette advertising's influence on youth are R. Pollay, et al., "The Last Straw? Cigarette Advertising and Realized Market Shares Among Youths and Adults," Journal of Marketing 60(2):1-16 (April 1996); and N. Evans, et al., "Influence of Tobacco Marketing and Exposure to Smokers on Adolescent Susceptibility to Smoking," Journal of the National Cancer Institute 87(20): 1538-45 (October 1995). See also, J.P. Pierce, et al., "Tobacco Industry Promotion of Cigarettes and Adolescent Smoking," Journal of the American Medical Association (JAMA) 279(7): 511-505 (February 1998) [with erratum in JAMA 280(5): 422 (August 1998)].

December 31, 1998

Previous

**Fact Sheets**

# The Toll of Tobacco in Wisconsin Since the MultiState Settlement Agreement was Signed

- **Wisconsin residents who have died from smoking-caused illnesses: 3,940**
- **Kids under eighteen who have become new daily smokers: 13,050**
- **Total spent on Wisconsin residents' tobacco-caused health problems: $691 million**
- **Medicaid expenditures in the State on tobacco-caused health problems: $99 million**

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**SOURCES**

**Adult Tobacco-Caused Deaths.** Estimated from state adult death data from U.S. Centers for Disease control and Prevention (CDC), State Tobacco Control Highlights (1998), which is available at the CDC website: http://www.cdc.gov/nccdphp/osh/statehi/statehi.htm. Daily rate calculated by dividing the state's average annual rate by 365.

**New Kid Smokers.** Based on the number of kids under 18 who become new regular smokers each day in the United States (more than 3,300) from CDC, "Incidence of Initiation of Cigarette Smoking - United States 1965-1996," Morbidity and Mortality Weekly Report (MMWR) 47(39): 837-40 (October 9, 1998). National number allocated to Wisconsin by calculating the state's share of all smokers under 18 in the United States using state-specific data from CDC, "Projected Smoking-Related Deaths Among Youth -- United States," MMWR 45 (44): 971-974 (November 8, 1996). MMWR articles are available at the CDC website: http://www.cdc.gov/epo/mmwr/mmwr.html.

**Total Tobacco-Caused Health Care Costs in State.** From L. Miller, et al., "State Estimates of Total Medical Expenditures Attributable to Cigarette Smoking, 1993," Public Health Reports 113:447-58 (September/October 1998). Annual amount for the state divided by 365 to obtain daily rate. The Wisconsin amount taken from this research article covers only those expenditures pertaining to the health problems of adults in the state caused by their own smoking. Accordingly, the amount listed above is quite conservative because it does not include: a) smoking-caused health costs for smokers under 19 years old; b) health costs caused by secondhand smoke; c) health costs for newborns and infants caused by mothers smoking or being exposed to second hand smoke during pregnancy; d) health costs from forms of tobacco use other than cigarette smoking; and e) health costs for injuries from cigarette-caused fires. The data presented in this chart also does not include the enormous non-health costs caused by tobacco in Wisconsin. For more information on these non-health costs, see e.g., U.S. Department of the Treasury, The Economic Costs of Smoking in the U.S. and the Benefits of Comprehensive Tobacco Legislation (11998) http://www.treas.gov/press/releases/docs/tobacco.pdf.

**State Medicaid Expenditures.** From L. Miller et al., "State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal year 1993," Public Health Reports 113: 140-151 (March/April 1998). See, also, L. Miller, et al., "State Estimates of Total Medical Expenditures Attributable to Cigarette Smoking, 1993," Public Health Reports 113: 447-58 (September/October 1998).

**To avoid any risk of overstating tobacco's toll on Wisconsin since the multistate settlement was signed, all amounts have been rounded down.**

*Previous*

Judith B. Robson
Wisconsin State Senator

**TESTIMONY OF SENATOR JUDITH B. ROBSON**
**ON SB 115**
**BEFORE THE SENATE HUMAN SERVICES AND AGING COMMITTEE**
**JULY 29, 1999**

Good afternoon. I am the author of Senate Bill 115, relating to health insurance coverage of smoking cessation treatment and medications.

SB 115 is a cost-effective way to save lives and save money for insurance companies, and ultimately their customers. But more importantly, it helps people quit a habit that kills 7800 people annually in Wisconsin.

Smoking cessation treatments offer the greatest opportunity to improve the current and future health of Wisconsin residents. Currently one in four Wisconsin adults smoke. It is essential that we take a proactive role in reducing the prevalence of tobacco use. An effective way to do that is through the support and delivery of effective smoking cessation interventions.

Everyone knows how hard it is to quit smoking. What you may not know is that smoking addiction is a medical condition that can be treated, just as we treat hypertension, alcoholism, and many other maladies. Medicine has now reached the stage where there are effective drugs and treatments that can effectively help people break a deadly habit. On average, it costs $167 for effective tobacco cessation. That is less than the cost of treatment for some of smoking side effects such as high blood pressure and high cholesterol, and it is certainly cheaper than treatment for cancer or a heart attack.

The biggest barrier to effective smoking cessation treatments is cost and insufficient insurance reimbursements. Insurance coverage of smoking cessation has been shown to increase the rates of cessation services utilization and therefore increases the number of people who smoke.

There is already a precedent for coverage for treatment of preventative care. A recent eight year-long insurance industry study found that reimbursing physicians for providing preventive care resulted in reported increases exercise, seat belt use, weight loss, and decreased alcohol abuse. There is already a proven record of prevention providing positive outcomes.

Smoking cessation treatments should be provided for subscribers of health insurance and managed care. That is why I authored SB 115 and I encourage your support.

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State Representative
**Spencer Black**

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STATEMENT OF REPRESENTATIVE SPENCER BLACK
REGARDING SENATE BILL 115
SENATE COMMITTEE ON HUMAN SERVICES AND AGING

Chair Robson and members of the Committee. Thank you very much for holding a hearing on this legislation. I am pleased to be the Assembly author of this legislation.

This legislation will require insurance companies, including HMO's, to cover smoking cessation treatment programs and medications conforming to guidelines issued by the Federal Agency for Health Care Policy and Research.

Most smokers want to quit, but it's not easy because tobacco is very addictive. Smokers receiving treatment are twice as likely to be successful breaking the tobacco habit as those who try on their own. Unfortunately, most state health insurance policies including those covering most state employees do not cover smoking cessation treatment. These programs, including medication, are not cheap. This bill will require that health insurance policies in Wisconsin cover these treatments and medications because the uninsured costs of smoking cessation programs often prevent, or at least, dissuade smokers from getting treatment and quitting.

Getting smokers into treatment makes more sense than ever. Recent research at the University of Wisconsin indicates that new treatments with the medicine Zyban are much more effective than previously used anti-smoking methods. Smoking costs our state almost $2 billion a year in health care costs and loss of productivity. Those are costs we all end up paying. It makes far more sense to prevent these costs by removing financial barriers that prevent and discourage smokers from getting the treatment they need to quit. Helping more Wisconsin residents quit smoking would help prevent future health care costs to the public. As the federal Agency for Health Care Policy and Research concluded, smoking cessation treatments are among the most efficient preventive measures at the disposal of health care professionals.

State Medical Society of Wisconsin
*Advancing the health of the people of Wisconsin*

**TO:** **State Senator Judy Robson, Chair**
**Members, Senate Committee on Human Services and Aging**

**FROM:** **M. Colleen Wilson, Legislative Counsel**
**Government Relations**

**RE:** **Support for Senate Bill 115**

**DATE:** **July 29, 1999**

The State Medical Society of Wisconsin appreciates the opportunity to express its support for Senate Bill 115 which requires health plans to provide coverage of smoking cessation treatment and specific smoking cessation medications. We applaud Senator Robson and the co-sponsors of this bold initiative for their efforts to ensure that smokers have the tools they need to rid themselves of a health-and-life threatening addiction.

As a partner in the TRUST Campaign, the State Medical Society has advocated for use of a portion of the settlement dollars for cessation activities. Physicians firmly believe that resources need to be devoted to helping smokers quit, including making those opportunities readily available through health insurance. Our state must make cessation a priority - and insurers need to acknowledge cessation treatment and medications as a health priority.

Tobacco addiction has a high price tag. Treating tobacco-related illnesses is an expensive proposition, and as more and more young people become nicotine addicts, those costs will only escalate. Covering cessation treatment and medication is an investment in both the financial and personal well-being of all Wisconsin citizens. The State Medical Society respectfully requests your support of SB 115.

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# Wisconsin Association of Health Underwriters

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Statement of the Wisconsin Association of Health Underwriters
to the
Senate Committee on Human Services and Aging
in
Opposition to Senate Bill 115

July 29, 1999

The members of the Wisconsin Association of Health Underwriters applaud the sponsors of Senate Bill 115 for their desire to curb smoking. Clearly, smoking produces terrible consequences for smokers, their families, their friends and the public at large, and smoking cessation should stand as an admirable public policy goal; therefore, WAHU and its members respectfully urge the Legislature and the State of Wisconsin to fund the goal from public monies, not private health-insurance premiums paid by groups and individuals.

The Legislature could reach far more people than reached by Senate Bill 115 by using state funds to pay for smoking cessation and medications for any and all citizens. Senate Bill 115 only provides payment for those individuals with health insurance. That group represents a relatively small percentage of the Wisconsin population -- perhaps as little as 25%. Less than half of the working citizens of Wisconsin get their health benefits from health insurance, which would fall under the provisions of Senate Bill 115. In other words, people in self-funded groups are not included, Medical Assistant recipients are not included, Medicare recipients are not included, and the uninsured would not be able to take advantage of Senate Bill 115.

Senate Bill 115, while phrased as a mandate on health plans, imposes the mandated coverage on individuals and groups who purchase health insurance. If more accurately rephrased to reflect the real consequences the Senate Bill 115, the analysis of Senate Bill 115 by the Legislative Reference Bureau would read:

> *This bill requires every insured person and insured group to purchase coverage* of smoking cessation treatment that is provided in conformity with recommendations set forth in a publication of the federal agency for health care policy and research, as well as coverage of certain specified smoking cessation medications. *The requirement applies to both individuals and group purchasers* of health insurance policies and plans . . .

Senate Bill 115 would impose this mandate, like all other mandates, on the purchasers of health insurance, not the insurance companies.

In the end, WAHU and its members must oppose Senate Bill 115.

**Mason, Cory**

**From:** LURIA, CHERYL N (US Sales) [CNL67204@glaxowellcome.com]
**Sent:** Wednesday, July 28, 1999 11:28 AM
**To:** 'cory.mason@legis.state.wi.us'
**Subject:** Cheryl Luria - GlaxoWellcome

SCRGAMPoints.doc

Cory,

Attached is information that we have used for testimony and communication on the issue of smoking cessation. I will check my voicemail later if you have any questions feel free to leave them there.

Again, I'm sorry that I can't be in Madison - but good luck with the hearing. Let me know if there is anything else we can help with.

Talk to you soon -

Cheryl Luria
GlaxoWellcome, Inc.
Voicemail 1-800-496-3772 Ext. 80134 <<SCRGAMPoints.doc>>

**Medicaid Should Cover Drugs**
**That Help People Stop Smoking**

The Medicaid population is particularly vulnerable to the health consequences of smoking. A study by the Center on Addiction and Substance Abuse at Columbia University revealed that more than 42 percent of Medicaid beneficiaries are current smokers, compared to less than 25 percent in the general population. The study also found that 1 in 5 Medicaid hospital days is due to substance abuse; 41 percent of these days are due to tobacco use.

It is important to grant access to these FDA-approved therapies to Medicaid beneficiaries for two major reasons. First, the Journal of the U.S. Public Health Service estimated that over the next 25 years, cigarette smoking will cost the Medicaid program $322 billion. Second, helping Medicaid beneficiaries stop smoking helps their children not smoke. Recent studies have shown that children of smokers are three times more likely to become smokers themselves. In addition, children of parents who smoke have been shown to be resistant to educational efforts warning them not to take up smoking. Thus, it is imperative that we aid this population that continues to smoke when they attempt to quit.

To improve the health of smokers within the Medicaid population and lower the medical cost burden associated with tobacco use, the Medicaid program should provide appropriate access to comprehensive smoking cessation programs and smoking cessation therapies approved by the U.S. Food and Drug Administration.

## Smoking Cessation Helps To Prevent Teen Smoking

Helping adult smokers to stop smoking can play a powerful role in preventing teens from smoking. No one questions the strong influence that parents and other adult role models can have on children. Given this influence, it is no surprise that research has shown the effect parents have on whether their children will begin to smoke and whether they will quit smoking if they begin.

As many as seventy-five percent of all teenage smokers come from homes where at least one parent smokes.[1] Research on the influence of smoking and parental attitude toward smoking has demonstrated two- and three-fold increases in the proportion of adolescent smokers when both parents smoked compared to when neither parent smoked.[2] Recent findings from the National Longitudinal Study of Adolescent Health found that easy access to cigarettes in the home was significantly associated with adolescent smoking, and nearly a third of the more than 10,000 adolescents surveyed nationwide reported easy home access to cigarettes.[3] In view of the results of this study, the CDC concluded that "[e]stablishing health-oriented social norms (e.g., by increasing provision of smoke-free indoor air and decreasing modeling of tobacco use by parents, teachers, and celebrities) and increasing support and involvement from parents and schools also will contribute to prevention."[4]

Parental smoking can also impact whether adolescent smokers will quit smoking before reaching adulthood. A study of adolescents surveyed over a ten-year period found that "adolescent smokers whose parents had also smoked were less likely to quit smoking by adulthood than were adolescent smokers whose parents had never smoked."[5]

Preventing adolescents from smoking has proven to be difficult. Currently, proposed solutions focus on "de-glamorizing" tobacco and reducing children's access to tobacco. Accordingly, great interest is paid to limiting the use of tobacco in movies and advertising. These proposals, however, often ignore the important influence of having a parent who smokes in the home. A truly comprehensive plan designed to prevent and reduce adolescent smoking should include smoking cessation to help smokers end the smoking legacy presented to children.

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[1] Office on Smoking and Health. *Smoking, Tobacco & Health: A Fact Book*, Washington, DC: US Dep't of Health & Human Services; 1989:7.

[2] *The Influence of Parental Attitude and Behavior on Early Adolescent Cigarette Smoking*, Journal of School Health 1989;59(4):150-52; *The Natural History of Cigarette Smoking from Adolescence to Adulthood: Demographic Predictors of Continuity and Change*, Health Psychology 1996;15(6):478-84.

[3] *Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health*, JAMA 1997;278(10):823-32.

[4] *Tobacco Use Among High School Students -- United States, 1997*, Morbidity and Mortality Weekly Report 1998:47(12):229-33.

[5] *The Natural History of Cigarette Smoking from Adolescence to Adulthood: Demographic Predictors of Continuity and Change*, Health Psychology 1996;15(6):478-84.

## Cessation Is Critical to Tobacco Control

Encouraging cessation and ensuring access to effective treatments are critical to preventing tobacco related illnesses. The prevention of tobacco-related illnesses is the ultimate goal of any tobacco control program.

For good reason, during tobacco control discussions a great deal of attention is focused on preventing youth from beginning to smoke. It is important to realize, however, that even if these efforts succeed in preventing half of the estimated 1,000 teenagers who begin to smoke each day from beginning to smoke, we would still have almost 200,000 new, young smokers each year. These future smokers and current smokers need access to effective cessation treatments if we are to reduce the substantial healthcare burden of tobacco-related illness.

# Increases in Health Insurance Spending Explain the Declining Rate of Coverage

*A new study finds that the decline in health insurance coverage among workers from 1979 to 1995 is largely the result of the increase in per capita health care spending. Health insurance is like most goods: The higher its price, the more people are priced out of the market. Low-income workers are disproportionately affected by the increase in health care spending. Using the U.S. Census Bureau's Current Population Survey, this study estimates the impact of per capita health care spending and workers' income on whether they have health insurance. (R. Kronick and T. Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979-1995," Health Affairs, Vol.18, March/April 1999)*

## Background

Each year from 1961 to 1996, health care expenditures per capita increased faster than general inflation.[1] Higher expenditures have been associated with increases in the number of Americans without health insurance.[2] This new study, by Richard Kronick and Todd Gilmer at the University of California at San Diego, rigorously estimated the magnitude of the impact of expenditures per capita on insurance coverage. These results reinforce previous research on the impact of legislative proposals on cost and coverage.

## Findings

◆The decline in health insurance coverage among workers from 1979 to 1995 can be accounted for almost entirely by the fact that per capita health care spending rose much more rapidly than personal income.

◆The percentage of workers with insurance remained constant for categories of workers whose income kept up with the increase of health care expenditures. But an increasing percentage of workers faced a high price relative to their income.

◆Low-income workers are disproportionately affected by the increase in health care spending. Whereas insurance coverage fell by eight percentage points for workers as a whole, it fell by 16 percentage points for low-wage workers (those earning $10,000-15,000 in 1980).

◆Changes in employment and demographic characteristics do not explain much of the drop. For example, although there was an increase in the percentage of part-time workers -- who are less likely to have insurance coverage -- this increase was not large enough to have a major impact on the percentage of workers without insurance.

## Discussion

Health insurance is like most goods: The higher its price, the more people are priced out of the market. Noting that "health insurance appears to be unaffordable for large numbers of low- and medium-wage workers," the authors conclude: "Those who see managed care as the enemy should keep in mind that limits on spending growth have had real benefits for workers, not just for employers and insurance executives."

The Kronick-Gilmer study lays out alternative futures: If expenditures grow at 7.5%, the percentage of workers without insurance would increase from 23% in 1995 to 30% in 2005 (see Table 1). If expenditures remain constant, the percentage without insurance coverage would be 20% in 2005--a difference of 10 percentage points. Each percentage point increase in health insurance premium is estimated to increase the number of workers without insurance by 0.12 %.

Table 1. **Alternative Futures: Percentage Uninsured Under Four Assumptions About Per Capita Health Care Expenditure Growth, 1995-2005**

| Four Per Capita Growth Assumptions | Percent Uninsured | | |
|---|---|---|---|
| | Year 1995 | Year 1999 | Year 2005 |
| +7.5% | 23% | 26% | 30% |
| +5.5% | 23% | 25% | 27.5% |
| +3.5% | 23% | 23.5% | 24.5% |
| 0.0% | 23% | 21.5% | 20% |

Source: Kronick, Gilmer, *Health Affairs*, Vol. 18, 1999

The extent to which various legislative proposals (e.g., any-willing-provider requirements, expanded health plan liability) would increase expenditures per capita is a concern of policymakers. The Kronick-Gilmer study will allow for more precise estimates of these increases.

A 1998 study in *Health Affairs* corroborates the Kronick-Gilmer study.[3] Reporting on a survey of employers, this earlier study found that the percentage of employees enrolled in a health plan fell by five percentage points between 1989 and 1996. The researchers found that while the percentage of firms that offered health insurance *increased*, more employees refused those offers.

## Methods

The average price of health insurance was imputed for each year using a variety of sources. The study used the *Current Population Survey* to measure health insurance coverage, earnings, and employment characteristics. For each individual in the survey (about 50,000 in a typical year), the price was divided by the respondent's personal income, yielding a price-per-income variable. A logistic regression was used to estimate this variable on the probability of being insured, controlling for employment and demographic characteristics.

1. K. Levit, et al., "National Health Spending Trends in 1996," *Health Affairs*, Vol. 17, January/February 1998
2. The Barents Group LLC, *Impact of Legislation Affecting Managed Care Consumers: 1999-2003*, April 21, 1998
3. P. Ginsburg, et al., "Tracking Small-Firm Coverage, 1989-1996," *Health Affairs*, Vol. 17, January/February 1998

For additional information, contact W. Peter Welch, Ph.D., Executive Director of Policy Research, at 202-778-8480.

**ASSOCIATION OF WISCONSIN HMOs**

State of HMO Quality in Wisconsin – 1999

| Measure | 1998 Wisconsin HMOs' Average | 1998 National Managed Care Plan Average |
|---|---|---|
| Advice to Quit Smoking | 68.5% | 62.5% |
| Beta Blocker Treatment | 83% | 79.9% |
| Breast Cancer Screening | 79.1% | 72.2% |
| Cervical Cancer Screening | 78.1% | 69.9% |
| Childhood Immunizations | 75.4% | 64.8% |
| Diabetic Eye Exams | 54.2% | 40.9% |
| 1st Trimester Prenatal Care | 89% | 83.6% |

Adapted from the National Committee for Quality Assurance (NCQA) 1999 Quality Compass

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# ADDICTIVE DISEASES

# Smoking Cessation Services Offered by Health Insurance Plans for Wisconsin State Employees

*by Eric Aakko, Thomas M. Piasecki, Patrick Remington, MD, MPH, and Michael C. Fiore, MD*

Abstract

Health insurance plans for state of Wisconsin employees were surveyed regarding the smoking cessation benefits offered to their members. Seven of the 25 plans (28%) cover some form of cessation treatment. Those plans that cover smoking cessation services differ substantially in the scope of benefits, and some have limitations and exclusions. These results suggest that smokers in Wisconsin are offered only limited insurance coverage for effective smoking cessation treatments.

## Introduction

Nearly 35 years have passed since the publication of the first Surgeon General's report documenting the deleterious health effects associated with smoking.[1] Over this period, appreciation of the enormous toll exacted by tobacco at the societal and individual levels has broadened among both medical professionals and the general public. Heightened awareness of the tobacco problem has recently culminated in diverse and vigorous attempts at tobacco control, including intensified youth prevention efforts, litigation and innovative legislative proposals.

Approximately 25% of the US adult population smokes cigarettes, contributing to over 419,000 premature deaths annually.[2] Attaining meaningful reductions in smoking prevalence will require a balanced approach, with resources dedicated to both prevention and cessation. Prevailing conditions suggest that a significant societal commitment to making smoking cessation a health care priority will yield enormous benefits. For instance, effective cessation interventions have been developed, researched and disseminated in recent years.[3] Smokers are highly receptive to these interventions, with 70% of smokers reporting a desire to quit smoking.[4] Extrapolating from these figures suggests that about 700,000 of Wisconsin's over 1 million smokers[5] are receptive to smoking interventions annually. A large majority of smokers visit physicians each year, providing ample opportunities for the delivery of cessation treatments.[6]

If smokers are interested in quitting and effective interventions exist, why do so many smokers continue to light up? The tenacious nature of nicotine addiction accounts for some of this discrepancy—smokers often need to make several serious quit attempts before attaining stable, long-term abstinence.[7] But institutional factors also contribute to this quandary. Specifically, health care systems have not yet established the infrastructure and clinical culture necessary to insure that all smokers are offered cessation services.[8] The inconsistent coverage of smoking cessation services among health insurance plans is emblematic of this larger institutional phenomenon.

In 1996, the Agency for Health Care Policy and Research (AHCPR) released its Smoking Cessation Clinical Practice Guideline,[9] an evidence-based review of available interventions which has since become recognized as the blueprint for a new standard of care in smoking cessation. The Guideline targeted health care administrators, insurers and purchasers as a core audience, and called for health insurance plans to cover interventions shown to be effective as paid services for all subscribers. A cost-effectiveness analysis of the interventions endorsed by the Guideline revealed that smoking cessation treatments are among the most efficient preventive measures at the disposal of health care professionals.[9]

The merits of universal smoking cessation coverage have received increased scrutiny since the release of the Guideline,[10-12] but many smokers still do not enjoy coverage for effective cessation interventions. We undertook this survey to assess the prevalence and quality of smoking ces-

Aakko is with Project ASSIST, Wisconsin Bureau of Public Health. Piasecki and Dr. Fiore are with the Center for Tobacco Research and Intervention, University of Wisconsin Medical School, and Dr. Remington is with the Department of Preventive Medicine, University of Wisconsin Medical School, Madison, WI.

sation benefits for Wisconsin smokers. Health insurance plans for state employees through the Department of Employee Trust Funds (DETF) were queried, because these plans cover the largest collectively-insured workforce in the state. Moreover, health care plans for government employees often serve as a bellwether signaling future trends in health care coverage.

## Methods

A brief telephone assessment was conducted in the spring of 1998, in order to examine how many health insurance plans pay for smoking cessation services (i.e., cessation counseling and/or pharmacotherapy), for Wisconsin's state employees. The state of Wisconsin employs over 36,130 Full Time Equivalent (FTE) employees.[1] During 1998, 25 health insurance companies provided regional coverage to state employees. The employee booklet for group health insurance plans entitled, "It's Your Choice, 1998," was used to identify and contact the plans. We contacted all of them and asked four primary questions:

1. "Does your health insurance plan pay for any smoking cessation services (i.e., counseling and/or pharmacotherapy) for Wisconsin state employees?
2. Does your health insurance plan pay for any smoking cessation counseling?
3. Does your plan pay for any cessation pharmacotherapy? And what kind of pharmacotherapy (nicotine replacement products and/or Zyban) are included?
4. Does your plan limit the number of times an enrollee can utilize these smoking cessation services?

Health insurance plans that did not pay for any cessation services were asked an additional, open-ended question: "Why not?"

**Table 1:** Health insurance plans providing cessation services for Wisconsin state employees, spring 1998.

**Plans which do not offer smoking cessation services:**
Atrium Health Plan
Compcare Health Services
Dean Health Plan
Group Health Cooperative of Eau Claire
Gundersen Lutheran Health Plan
Wisconsin Physicians Service (HMP- 90)
Humana/Emphesys Wisconsin
La Crosse Care Plus
Managed Health Services
Midwest Security Choice
Network Health Plan
North Central Health Protection Plan
Physicians Plus
Prevea Health Plan
Prime Care
Security Health Plan of Wisconsin
Unity Health Plans
Valley Health Plan

**Plans offering coverage for smoking cessation counseling only:**
Medical Associates Health Plan
United Health of Wisconsin

**Plans offering coverage for pharmacotherapy only:**
Standard Plan and SMP - BCBS United of Wisconsin

**Plans offering coverage for both cessation counseling and pharmacotherapy:**
Family Health Plan
Group Health Cooperative – SCW
Maxicare Health Insurance
Mercy Care

## Results

Of the 25 health insurance plans available to Wisconsin state employees, seven (28%) pay for smoking cessation services; 18 (72%) do not (Figure 1). The health insurance plans providing and denying smoking cessation services are listed in Table 1. Of the seven health insurance plans that pay for cessation services, two provide counseling alone, one provides pharmacotherapy alone, and four provide both counseling and pharmacotherapy.

The cessation counseling services offered by the six plans range from an initial private consultation to group behavior modification. Most plans (5/6) do not require a co-pay for the counseling. However, all required the enrollee to initially pay for the service and then later reimbursed partially or wholly. Most cessation counseling is offered through the plan's affiliated hospital network or health education program. The payment for cessation counseling ranges from a low of $25 (Medical Associates Health Plan), to a high of $310 (United Health of Wisconsin). Other plans refund an enrollee's initial payment if they remain smokefree. For example, Group Health Cooperative-South Central Wisconsin (SCW), requires an initial $120 pre-payment, however $60 is refunded after six months, and the balance after 12 months, if the enrollee remains smokefree for the entire year.

The pharmacotherapy offered by the five plans pay for nicotine replacement (Table 2). All of the five plans paid for nicotine replacement products, with some variability in the specific products covered (Table 2). All five plans covered the prescription drug bupropion (Zyban™). A co-pay is required with all five managed care plans. The co-pay ranges from $4 for generic and $8 for name brand products with Maxicare Health Insurance, to a $25 yearly deductible with 80% insurer payment with the Standard Plan (Blue Cross Blue Shield United of Wisconsin). The Family Health Plan requires a $10 per week user fee for pharmacotherapy, while Mercy Care and

**Table 2:** Assessment of health insurance plans and smoking cessation services for Wisconsin state employees

Total number of health insurance plans, n = 25

| | Yes | % | No | % |
|---|---|---|---|---|
| 1. Does the health insurance plan pay for smoking cessation services (counseling and/or pharmacotherapy) | 7 | (28%) | 18 | (72%) |
| 2. Does the health insurance plan pay for smoking cessation counseling? | 6 | (24%) | 19 | (76%) |
| a. Is a co-pay required for counseling? | 1 | | 6 | |
| 3. Does the health insurance plan pay for pharmacotherapy (nicotine replacement)? | 5 | (20%) | 20 | (80%) |
| a. Nicotine Gum | 2 | | 3 | |
| b. Nicotine Nasal Spray | 1 | | 4 | |
| c. Nicotine Patch | 4 | | 1 | |
| d. Zyban™ | 5 | | 0 | |
| e. Is a co-pay required for pharmacotherapy? | 5 | | 0 | |
| 4. Does the health insurance plan limit the number of times an enrollee can utilize the cessation services? | 5 | | 2 | |
| a. Yearly limit on paid services* | 2 | | 3 | |
| b. Lifetime limit on paid services* | 4 | | 1 | |

* Limitations may involve a cap on cessation counseling, but not on pharmacotherapy, or vice versa.

Group Health Cooperative-SCW, will provide reimbursement for nicotine replacement products if enrollees remain smokefree over an extended period of time. Several of the plans require joint cessation counseling (behavior modification classes) with the pharmacotherapy. A majority of the managed care plans put either a lifetime or yearly cap on the amount of utilization of the cessation services. However, Family Health Plan and Group Health Cooperative-SCW, did not have either a lifetime or yearly cap on their paid services.

Most of the 18 health insurance plans responded to the open-ended question and summarized why they do not provide smoking cessation services to Wisconsin state employees. Most noted that the Department of Employee Trust Funds did not negotiate for this type of service, so they do not provide it. Several plans stated that cessation is not considered a medical priority. Others said paying for cessation services was redundant because many people quit on their own and there are nicotine replacement products available without a prescription.

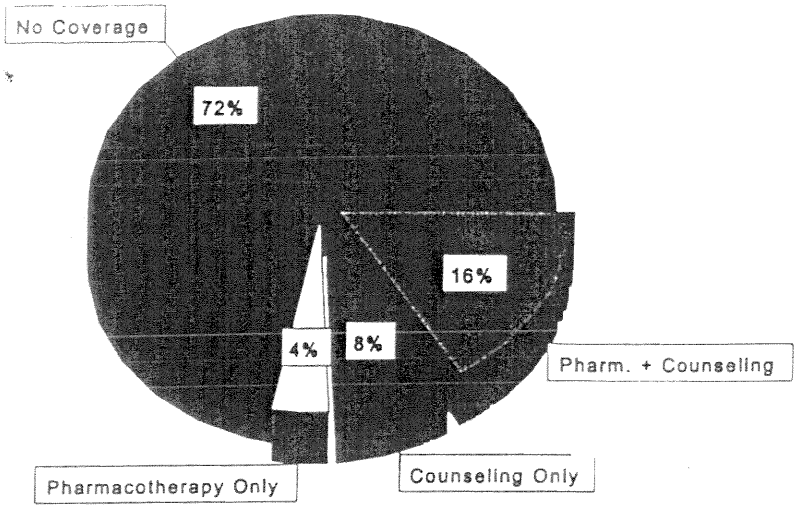
## Discussion

By any standard, it must be considered disappointing that nearly three quarters of the health insurance plans available to state employees in Wisconsin provide no coverage whatsoever for smoking cessation services. Open-ended responses from plans that do not offer coverage hint at some of the barriers to universal coverage for cessation treatments. Many plan representatives noted that cessation services were not covered because the Department of Employee Trust Funds did not include cessation treatments as a component of their negotiations with plan administrators. This suggests that employers may need to shoulder some of the responsibility for providing access to cessation by insisting upon cessation benefits for their employees.[14]

Other reasons cited for lack of coverage betrayed some enduring institutional myths about smoking cessation. For instance, some plans stated that smoking cessation was not a medical priority. It is ironic that this viewpoint persists even while most of these same organizations cover the very expensive medical costs associated with the endstage morbidity resulting from smoking. Additionally, plans noted that, since many smokers quit without assistance, and since nicotine replacement is now available without prescription, there is no need to provide cessation coverage. This reasoning has an intuitive appeal, but is not supported by research, that shows that even very brief clinical interventions produce many-fold increases in long-term abstinence[3] — put simply, clinicians can do better. Moreover, it is clear that smokers vary dramatically in terms of their motivation for smoking and their preferred methods of quitting,[15] suggesting a need for access to a broad range of services. This perspective was supported by a recent study documenting increased utilization of smoking cessation services if they were covered benefits for managed care enrollees.[16]

On the other hand, it may be considered encouraging that about 25% of plans available to state employees offer coverage for some cessation services despite the fact that the Department of Employee Trust Funds did not make such coverage compulsory. Such voluntary coverage may

**Figure 1**. Smoking Cessation Coverage for State Employees




indicate a growing appreciation among insurance administrators that cessation coverage promotes the health of their members and curbs long-term health care costs.

The seven plans providing cessation coverage varied substantially in the types of services covered, co-pays, deductibles, and lifetime and yearly caps on benefits. Such variations are perhaps natural as managed care organizations begin to test the waters. Ideally, however, a universal benefits package will be developed that becomes an industry standard. This would benefit both smokers and their insurers. Smokers would benefit by being free to select any plan with the assurance that they will receive cessation coverage. Individual managed care organizations could be reasonably certain that they will reap the long-run economic savings associated with cessation, even in the face of significant turnover of individual members.

An industry standard for smoking cessation benefits might take several forms, but achieving the optimal combination of health promotion and medical care savings will require two specific components. First, the services covered must be *proven effective*. Only pharmacotherapies and devices approved by the FDA and cessation programs sanctioned in the AHCPR Guideline should be covered. Restricting coverage to these proven therapies will encourage their use, thereby optimizing overall cessation rates, and prevent wasteful spending for ineffective programs. Second, coverage must provide for *flexible* and *repeatable* treatment. Not all smokers benefit equally from a given intervention, and smokers differ in terms of which interventions they find appealing and/or acceptable.[15,17] A coverage policy that does not provide smokers with a choice of treatments runs the risk of deterring some smokers. Additionally, studies indicate that most smokers make several serious attempts at quitting before they achieve long-term abstinence.[1] Given this, it is clear that stringent caps on the lifetime utilization of cessation benefits can have only a very limited effect on smoking behavior at the population level.

## Conclusion

Only about one-quarter of health insurance plans available to state employees in Wisconsin provide some coverage for some form of smoking cessation treatment. Parameters of coverage vary substantially across plans that do provide smoking cessation benefits. Assuming these health plans are representative of other plans statewide, most Wisconsin residents have limited access to proven cessation therapies. Managed care organizations in Wisconsin should strive to meet the AHCPR recommendation of universal cessation benefits for all beneficiaries.

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# Smoking Cessation

## *a systems approach*

**A Guide for Health Care Administrators, Insurers, Managed Care Organizations, and Purchasers**

Health care systems face the daily challenge of balancing quality of care and costs for every patient. As health care administrators, insurers (including managed care plans), and purchasers, you play a vital role in tackling the leading preventable cause of illness and death—smoking. The most successful smoking cessation programs are supported by institutional policies. They incorporate reimbursement practices, clinical and systems procedures, incentives for providers, and clinician education. Interventions by many kinds of health care providers are also powerful components of successful programs. This brochure is intended to reach a broad audience; readers should consider how the key points could be addressed from their particular vantage point in the system.

The purpose of this guide is to provide you with tools to make smoking cessation a priority in your organization. You can help eliminate the roadblocks to developing standard procedures for assessment and treatment of tobacco use in every health care setting. Substantive change can occur when systems and providers work in tandem.

- Americans spend an estimated $50 billion annually on direct medical care for smoking-related illnesses. Lost productivity and forfeited earnings due to smoking-related disability account for another $47 billion per year.
- The average cost per smoker for effective cessation treatment is $165.61.
- Smoking cessation interventions are less costly than other routine medical interventions such as treatment of mild to moderate high blood pressure or high cholesterol and preventive medical practices such as periodic mammography.
- Smoking cessation interventions can save on costs by reducing health risks and complications for infants and young children.

Supporting institutionwide smoking cessation programs can yield both short- and long-term cost savings for patients. Working to make institutional change impacts not only the health of your patients but also the quality and costs of care.

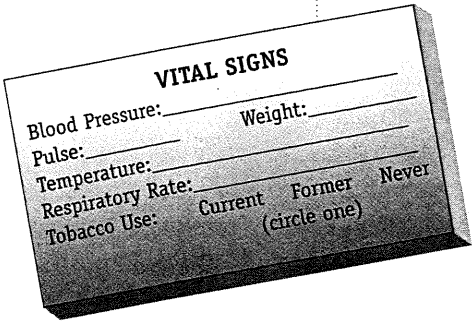
## *Strategies That Work*

Effective smoking prevention interventions are readily available now and, if provided in a timely and effective manner, greatly reduce the smoker's risk of suffering from smoking-related disease. Following are five strategies that have been demonstrated to be effective in helping health care providers identify and treat tobacco users. Health care administrators, insurers, and purchasers each have an important role in promoting adoption of these strategies. For example, administrators can develop policies to be implemented at the office, clinic, and hospital levels; insurers, including managed care plans, can promote implementation through contract specifications, incentives, and performance expectations; and purchasers can tailor their agreements with insurers and delivery organizations to ensure that smoking cessation interventions are addressed at the delivery system level. Costs for implementing these strategies will vary among individual health plans depending on a plan's population mix, location, personnel conducting the intervention, intervention preferences of its members, and other variables such as costs for screening, advice, motivation, and counseling.

## Strategy 1. Implement a tobacco-user identification system in every clinic

*Evidence*: Screening systems that systematically identify and document smoking status result in higher rates of smoking cessation interventions by clinicians and in higher quit rates among patients who smoke. This approach increases the probability that tobacco use is consistently assessed and documented. Studies show that smoking cessation interventions involving minimal contact with health care providers—physicians, nurses, social workers, counselors, and others—even in sessions lasting as few as 3 minutes, are more effective at increasing cessation rates than no contact at all. Intensive interventions are more effective and should be used when resources permit. Health care report cards such as the Health Plan Employer Data and Information Set (HEDIS) are now mandating that managed care organizations include information documenting delivery of effective smoking cessation services.

| Action | Strategies for implementation | |
|---|---|---|
| Implement an office-wide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is queried and documented. | **Office system change:** | Expand vital signs data to include tobacco use (see sample diagram below). |
| | **Responsible staff:** | Nurse, medical assistant, receptionist, or other individual already responsible for measuring the vital signs—no additional staff requirements. These staff must be instructed regarding the frequency and importance of this activity. |
| | **Frequency of utilization:** | Every visit for every patient regardless of the reason that brought the individual to the clinic. In other words, whenever health care staff collect the traditional vital signs data, they should query and document tobacco use.* |
| | **System implementation steps:** | Preprint note paper or preprogram computer record for every patient visit to include tobacco use along with the traditional vital signs. A vital sign stamp can also be effective. Alternatives to the vital sign stamp are to place tobacco-use status stickers on all patient charts or to indicate smoking status using computer reminder systems. |




*Repeated assessment is not necessary in the case of the adult who has never smoked or not smoked for many years, and for whom this information is clearly documented in the medical record.

## Strategy 2. Provide education, resources, and feedback to promote provider intervention

*Evidence.* Smoking cessation interventions delivered by multiple types of health care providers (e.g., nurses, dentists, psychologists, social workers) markedly increase cessation rates compared with interventions where no provider intervenes (e.g., self-administered interventions). Results are consistent across diverse provider groups, with no clear advantage to any single provider type. To encourage provider interventions, health care administrators, insurers, and purchasers should provide both training and incentives, such as reimbursement for clinicians (see strategy 5). It is important to dedicate staff both to provide smoking cessation treatment and to assess the delivery of this treatment in staff performance evaluations.

National data suggest that, in a given visit with a clinician, most smokers are not advised to quit smoking and are not assisted with cessation. Factors that contribute to this problem include failure to (a) include smoking assessment and cessation in the performance expectations of clinicians and (b) provide clinicians with an environment that supports systematic intervention with smokers. Without supportive systems, policies, and environmental prompts, the individual clinician cannot be counted on to assess and treat tobacco use reliably.

| Action | Strategies for implementation |
|---|---|
| ■ Health care systems should ensure that clinicians have the knowledge and training to treat smoking, that clinicians and patients have cessation resources, and that clinicians are given feedback about their cessation practices. | **Educate**—On a regular basis, offer lectures/seminars/in-services with CME and other credit for smoking cessation treatment.<br><br>**Resources**—Have patient self-help materials, as well as nicotine replacement "starter kits," readily available in every exam room.<br><br>**Provide feedback**—Drawing on data from chart audits, electronic medical records, or computerized patient databases, evaluate the degree to which clinicians are identifying, documenting, and treating patients who smoke, and provide feedback to clinicians about their level of intervention. |
| ■ Clinical sites should communicate to staff the importance of intervening with smokers and should designate one staff person (e.g., nurse, medical assistant, or other clinician) to coordinate and deliver smoking cessation treatments. | **Communicate** to each staff member (e.g., nurse, medical assistant, or other clinician) his or her responsibilities in the delivery of smoking cessation services.<br><br>**Designate** a smoking cessation treatment coordinator for every clinical site.<br><br>**Delineate** the responsibilities of the smoking cessation coordinator, including instructing patients on the effective use of cessation treatments (e.g., nicotine replacement therapy, telephone calls to and from prospective quitters, and scheduled followup visits, especially in the immediate post-quit period). |

## Strategy 3. Promote hospital policies that support and provide smoking cessation services

*Evidence.* Every hospital in the United States must now be smoke free if it is to be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Implementing inpatient smoking cessation programs increases the rate at which hospitalized patients successfully quit. It is vital that hospitalized patients attempt to quit smoking because smoking may interfere with their recovery. Hospitalized patients may be particularly motivated to make a quit attempt for two reasons. First, the illness that resulted in their hospitalization may have been caused or exacerbated by smoking. Second, the hospital's smoke-free environment may enhance their motivation to quit. In addition, systematic, institutionalized mechanisms to identify exsmokers is a necessary first step in delivering relapse prevention messages. Furthermore, all clinicians have an important role as nonsmoking models for their patients.

| Action | Strategies for implementation |
|---|---|
| Provide smoking cessation inpatient consultation services to all smokers admitted to a hospital and to all health care personnel who smoke. | **Implement** a system to identify and document the tobacco-use status of all hospitalized patients.<br><br>**Offer** cessation treatment to all hospitalized patients who use tobacco.<br><br>**Identify** a clinician(s) to deliver smoking cessation inpatient consultation services for every hospital.<br><br>**Reimburse** providers for smoking cessation inpatient consultation services.<br><br>**Expand** hospital formularies to include effective smoking cessation pharmacotherapy such as the nicotine patch and nicotine gum.<br><br>**Ensure** compliance with JCAHO regulations mandating that all sections of the hospital be entirely smoke free.<br><br>**Educate** all hospital staff regarding nicotine withdrawal, including effective treatments such as nicotine replacement therapy and counseling. |

## Strategy 4. Include smoking cessation treatments as paid services in all health benefits packages

*Evidence.* Smoking cessation treatments (both pharmacotherapy and counseling) are not consistently provided as paid services for subscribers of health insurance packages. The level of coverage is particularly surprising given that studies show that physician counseling against smoking is at least as cost-effective as several other preventive medical practices, including the treatment of mild or moderate hypertension or high cholesterol.

The national health promotion and disease prevention objectives for the year 2000 as set forth in *Healthy People 2000* propose to increase to 100 percent the proportion of health plans that offer treatment of nicotine addiction, such as tobacco-use cessation counseling by health care providers, tobacco-use cessation classes, prescriptions for nicotine replacement therapies, and/or other cessation services.

## Strategy 4. Include smoking cessation treatments as paid services in all health benefits packages

| Action | Strategies for implementation |
|---|---|
| Provide coverage to all insurance subscribers for effective smoking cessation treatments, including pharmacotherapy (nicotine replacement therapy) and counseling. | **Coverage**—Include effective smoking cessation treatments (both pharmacotherapy and counseling) as part of the basic benefits package for all individual, group, and HMO insurance packages.<br><br>**Evaluate**—Include the provision of smoking cessation treatment as part of "report cards" for managed care organizations and other insurers (e.g., Health Plan Employer Data and Information Set [HEDIS]).<br><br>**Educate**—Inform subscribers of the availability of covered smoking cessation services and encourage patients to use these services. |

## Strategy 5. Address effective smoking cessation treatment in clinician compensation agreements

*Evidence.* Primary care clinicians frequently cite insufficient insurance reimbursement as a barrier to providing preventive services such as smoking cessation treatment. Insurance coverage has been shown to increase rates of cessation services utilization and therefore increase rates of quitting. Even the presence of prepaid or discounted prescription drug benefits increases patients' receipt of prescribed nicotine gum, the duration of gum use, and smoking cessation rates. Furthermore, an 8-year insurance industry study found that reimbursing physicians for providing preventive care resulted in reported increases in exercise, seat belt use, and weight loss, as well as decreased alcohol use and a trend toward decreased smoking.

Smoking cessation treatments (both pharmacotherapy and counseling) should be provided as paid services for subscribers of health insurance/managed care. Clinicians should be reimbursed for delivering effective smoking cessation treatments. Even if a smoker does not want to quit, clinicians are encouraged to ask questions at each visit that help the patient identify reasons to quit and barriers to quitting. Clinicians should pledge to assist the patient when he or she is ready to quit. For patients willing to attend such programs, insurers should encourage referral to intensive programs through education and incentives to primary care providers.

| Action | Strategies for implementation |
|---|---|
| Reimburse fee-for-service clinicians for delivery of effective smoking cessation treatments; include smoking cessation treatments in the defined duties of salaried clinicians. | **Include** smoking cessation treatment as a reimbursable activity for fee-for-service providers.<br><br>**Inform** fee-for-service clinicians that they will be reimbursed for using effective smoking cessation treatments with every patient who uses tobacco.<br><br>**Include** smoking cessation intervention in the job description and performance evaluation of salaried clinicians. |

## Costs of smoking cessation interventions

The following table shows the average cost for each smoking cessation intervention, assuming that the entire U.S. population over the age of 18 years would be willing to undergo an intervention to quit smoking. The cost is the total average cost per smoker and includes the costs of screening, advising, motivation, and direct intervention with and without nicotine replacement for the interventions indicated. Across all types of interventions, the estimated cost per smoker is $165.61. The cost of each intervention varies according to the amount of provider counseling, the provision of nicotine replacement therapy, and the effectiveness of the intervention.

**Total cost per smoker of smoking cessation interventions with and without nicotine replacement**

| Intervention | Without nicotine replacement | With transdermal nicotine | With nicotine gum |
|---|---|---|---|
| Minimal counseling (≤ 3 min in duration) | $33.20 | $167.11 | $172.18 |
| Brief counseling (> 3 min to ≤ 10 min) | $56.48 | $185.57 | $192.40 |
| Full counseling | $94.24 | $231.30 | $246.34 |
| Individual intensive counseling | $123.19 | $255.01 | $271.01 |
| Group intensive counseling (7 1-hour sessions) | $71.83 | $203.65 | $219.65 |

*Source: Cromwell J, Bartosch W, Mitchell J. The cost effectiveness of AHCPR's smoking cessation guideline. Health Economics Research, Inc. Waltham, MA. December 1996 (contract analysis under direction of AHCPR).*

## To Get More Information

The information in this guide was taken from the *Clinical Practice Guideline on Smoking Cessation*. For more information about the guideline and related products, or to get more copies of this guide, call toll free 800-358-9295 or write to: AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907.

The full text of guideline documents is available online through AHCPR's web site (http://www.ahcpr.gov/guide/). Copies of this and other booklets are free through InstantFAX, which operates all day every day. Using a fax machine equipped with a touchtone telephone, dial (301) 594-2800, push 1, and then press the fax machine's start button for instructions and a list of publications.

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Rockville, MD 20852
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# *The ROSCO Software Model*

## *Return On Smoking Cessation Opportunity*

# Table of Contents

# Background

The economic benefits of smoking cessation result from a decreased prevalence of smoking-related illnesses and the cost of treating these illnesses in smokers, former smokers, and members of their households. In addition to its negative impact on health, cigarette smoking is responsible for substantial costs, both healthcare related and non-healthcare related. Smoking cessation can reduce the risk of smoking-related illnesses and associated costs.

Historically, smoking cessation products have had low efficacy rates compared to other pharmaceutical products approved for use by the FDA. Therefore, the perception among some health plans and employers is that the products are ineffective. In addition, illnesses that are associated with smoking, and are thus prevented when a patient quits smoking, are perceived to be long-term illnesses that occur years into the future for most patients. Thus, the perception of a health plan or employer may be that benefits of smoking cessation occur so far into the future that smoking cessation is a questionable financial investment. Furthermore, if health plans and employers have high turnover rates and continue to think that efficacy of smoking cessation interventions is low, the perception of questionable benefits will remain prevalent.

To address these issues and concerns, Glaxo Wellcome Inc. took several steps.

### 1. ROSCO Regional Estimates:

Glaxo Wellcome engaged Towers Perrin to provide a credible per member per month (pmpm) cost or per employee per year cost (pepy) and rate of return for managed care customers and employers. To accomplish this Towers Perrin developed a model based on their client data in four regions of the United States. They produced estimates for pmpm or pepy and rate of return for covering a smoking cessation benefit which includes Zyban® (bupropion hydrochloride) Sustained-Release Tablets. Estimates were produced for an employer and a health plan for each of the four regions (eight total estimates). These results are available as a packet and a leave behind to be used with customers by Glaxo Wellcome National Account Managers, Corporate Health Managers, and Regional Medical Scientists. These two pieces give the results for a health plan and an employer in each of the four regions using Towers Perrin client data.

### Towers Perrin

Towers Perrin is recognized by those in managed care as one of the largest and most conservative health benefits consultants. They are hired by employers to help set health insurance rates for employee populations, by health plans to predict medical and pharmacy costs, and by state governments to assist in regulation of health insurance rates.

## 2. ROSCO Software Model:

The Towers Perrin regional estimates are specific not only to geographical location but also to employer type (i.e., textile company, manufacturing company). Therefore, these estimates may not be completely representative of other employer types and may not be the most accurate estimate for a specific health plan or employer customer. Feedback from customers and from GW personnel using the ROSCO packet and leave behind suggests that a certain percentage of customers would like to see estimates based on their own population data to provide the most accurate estimates possible. To address this concern, the ROSCO software model was developed.

### Construction of the Model

Towers Perrin created their model using a combination of their own clients' data and published literature. However, the model relied heavily on their proprietary client cost data and was very specific to the four employer/health plan types selected for the regional estimates. In order to make the model useful to all of Glaxo Wellcome's health plan and employer customers, some adaptation of the original Towers Perrin model was necessary. Adaptations to the model were made in three areas:

1. Updating the model with more current information (Cromwell et al, 1997)
2. Making the model more transparent and user friendly
3. Using national data representative of many employer types and data specific to different states in the United States, where Towers Perrin had used data from a single client. This allows the model to perform calculations specific to various employer types in different locations of the country.

# Objectives

The objectives of the ROSCO software model are:

- To show the benefit of covering a smoking cessation benefit including Zyban
- To substantiate that smoking cessation is a good investment
- To allow for variation of assumptions underlying the four regional estimates to obtain estimates more applicable to specific populations
- To show the per member per month or per employee per year cost of covering a smoking cessation benefit including Zyban
- To encourage decision makers to include effective smoking cessation treatments

- To promote the use of smoking cessation programs to increase the health status of a health plan's or employer's population and to decrease overall healthcare costs.

# WHAT ROSCO DOES

This user-friendly graphic computer software was developed to allow employers (or decision makers in a managed care organization) to quickly and easily view and explore the impact of smoking cessation on health and economic outcomes over designated periods of time. ROSCO follows a group of employees or health plan members from the start of the model through either retirement (age 65) or to death. The program provides default values for personnel and intervention characteristics, but allows users to modify these values.

ROSCO presents a variety of results, including number of cases of smoking-related illness, medical costs, and non-medical costs incurred over time with and without coverage of smoking cessation aids. Results are presented graphically for ease of demonstration or in numerical tables.

# HOW ROSCO WORKS

## MODEL INPUTS

Inputs are listed in Tables 1 and 2. Additional information is given below and in the assumptions section which follows.

## POPULATION CHARACTERISTICS

The decision model allows users to define the characteristics of the employed (or health plan) population. This includes the number of personnel by age and gender; the number (or proportion) of employees in each of several job classifications (e.g., clerical/administrative, labor, managerial); the type of industry (e.g., manufacturing, profession service, design); and the region of the United States (e.g., northeast, southeast, midwest, west). Model users are required to specify their population size, industry or health plan type, and US region (pull down menus allow selection of other industry types and US regions). Default

# MODEL INPUTS

## TABLE 1. ROSCO MODEL INPUTS*

| Input | Source for default |
|---|---|
| Type of organization | CPS, 1997 |
| Region | Defined geographic regions (4) |
| State | |
| Number of employees/members | |
| Number of adult dependents | 60% of employees/members-Towers Perrin data |
| Model mode | |
| Level of counseling | |
| Intervention availability | |
| Age and gender breakdown of workforce/health plan membership | CPS, 1997 |
| Age and gender breakdown of adult dependents | |
| Family size | Towers Perrin data |
| Turnover rate | |
| Distribution of employees by occupation type | CPS, 1997 |
| Mean hourly wage by occupation type | CPS, 1997 |
| Additional absenteeism days/year | Warner et al, 1996 |
| Decreased productivity | Towers Perrin data |
| Additional annual direct costs | |
| Additional annual indirect costs | |
| Discount rate | Gold et al, 1996 |

| Input | Source for default |
|---|---|
| Medical expenses by smoking status | Hodgson, 1992 |
| Medical expenses by gender | From cost by smoking status and proportion of never and former smokers |
| Medical expenses per family | From costs by gender, proportion of males and females, family size, and Towers Perrin adult load factor |
| Participation rate without coverage | MMWR, 1994 |
| Participation rate with coverage | MMWR, 1994 modified by Towers Perrin promotion load factor |
| Smoking cessation success rates by level of counseling | Glaxo Wellcome data, Tonnesen et al 1998, and Cromwell et al, 1997 |
| Proportion participating in each type of intervention, with and without coverage | Towers Perrin data and Glaxo Wellcome data |
| Level of intervention promotion | Towers Perrin data and Glaxo Wellcome data |
| Presence of promotion for Zyban | Towers Perrin data |
| Proportion of physician visits for Zyban due only to smoking cessation | Towers Perrin data |
| Time off of work for Zyban physician visit | Towers Perrin data |
| Physician visit cost | 1997 Physician Fee & Coding Guide |
| Cost of Zyban | 1998 Red Book and Glaxo Wellcome data |
| Dosing and length of therapy with Zyban | Glaxo Wellcome data |
| Cost of cessation interventions | Cromwell et al, 1997 |
| Recidivism rate | Smoothed function of 1990 Surgeon General's Report data |

| Input | Source for default |
|---|---|
| Lung cancer costs | Riley et al, 1995 |
| COPD costs | Strauss et al, 1986 |
| CAD costs | Oster et al, 1984 |
| CVD costs | Taylor et al, 1996 |
| Pregnancy complication costs | Marks et al, 1990 and Halpern et al, 1996 |
| Smoking status by age and gender | NHIS, 1993 |

*Full references for published literature are available in the Reference List attached. If the reference is a government database, it is described briefly in the assumptions section which follows.