

# **Employers and Smoking Cessation:**

**Perceptions, attitudes, and knowledge about smoking cessation benefits**

Prepared for the California Tobacco Control Alliance

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## **Executive Summary**

The California Tobacco Control Alliance is pursuing the implementation of smoking cessation benefits in California. In order to gain an understanding of the employer's role in implementing benefits and the influence of employees in the decision-making process, the Alliance conducted a survey of California employers. A total of 15 different California employers were interviewed, with key question areas including organizational information, benefit selection process, current benefits, smoking cessation benefits, and benefit communications.

When making decisions about benefits, employers are most influenced by benefit cost and employee demand. Both of these factors seem to have swayed employers against the immediate implementation of cessation benefits. Employers are extremely sensitive to rising healthcare costs and for the most part were not receptive to implementing any program that would incur additional costs. Companies interviewed also largely perceived that smoking was not a problem in their workforce, and therefore a specialized benefit need not be implemented.

Research has demonstrated that both of these perceptions are flawed. Adding a smoking cessation benefit to a company's package has a minimal cost, especially when compared to the annual expenses related to smoking. Also, in a recent survey, employees have expressed an interest in and willingness to pay for smoking cessation benefits.

The Alliance can overcome these misperceptions through raising awareness in California employers. The first key strategy should be to create a compelling, employer-specific business case. They can then utilize employees, labor unions and insurance brokers to gain access to employers, and facilitate message delivery.

## **Introduction**

It is well established that smoking is a pervasive behavior with serious health consequences. In California, the adult smoking prevalence rate is 16.6%, meaning there are over four million smokers in the state<sup>1</sup>. Smoking is the leading preventable cause of death in the United States<sup>2</sup>, and is known to cause heart disease, stroke, multiple cancers, respiratory diseases and other costly illnesses.

Smoking is also one of the costliest medical conditions, with an estimated annual cost of \$3,400 per smoker per year<sup>2</sup>. Employers absorb part of this cost through higher medical expenses and lost productivity, as smokers incur more in lifetime medical expenses and are absent from work more than non-smokers<sup>2</sup>. It is known that 75% of smokers want to quit<sup>3</sup>, and that tobacco use treatment doubles quitting success rates. It is also known that less than one-fourth of employers offer any coverage for tobacco-use treatment<sup>2</sup>, despite the fact that it costs approximately \$3 per member per year to provide comprehensive tobacco cessation benefits<sup>4</sup>.

The California Tobacco Control Alliance, (the Alliance), is pursuing the implementation of smoking cessation benefits in California. The Alliance, a statewide, comprehensive, and collaborative coalition of public health, government, health care and advocacy organizations recently commissioned reports to investigate health plan and provider roles in implementing cessation benefits. They are now interested in finding out employers' and benefits purchasers' perceptions, attitudes and knowledge about cessation benefits, and the degree to which benefits are already implemented.

## **Project Description**

In their effort to expand the adoption of smoking cessation benefits, the Alliance has formed new strategic partnerships with managed care organizations and prominent members of private industry. A primary focus of the Alliance is the Managed Care Initiative, which promotes the following objectives:

- To demonstrate the benefits of making tobacco control a top priority for California managed care organizations with respect to economics, health improvements to members, political environment, and public relations.
- To identify barriers and challenges to elevating smoking cessation as a top priority, and provide solutions and resources that have been effectively implemented in managed care settings.
- To enlist consumers and purchasers of health care as key constituents in raising demand for tobacco cessation services.

Important stakeholders in the managed care initiative are California employers. In order to gain an understanding of the employer's role in implementing benefits and the influence of employees in the decision-making process, the Alliance conducted a survey of California employers. This report summarizes the results of the survey, including employer perceptions about cessation benefits, and proposes avenues for widening implementation and acceptance of cessation benefits.

## **Methodology**

Data was collected through a series of interviews with California employers, and analysis of existing reports and literature. The interviews were held from February-March 2004. Interviewees were selected from various employers to ensure an adequate cross-

section of size, industry and location. A large California purchasing group was also interviewed.

A total of 15 different California employers were interviewed, with key characteristics outlined below:

**Table 1 Survey respondent characteristics**

<b>Size (California employees)</b>	<b>Interviews</b>	<b>Industries</b>	<b>Estimated smoking prevalence</b>
Small (<1,000)	10	<ul style="list-style-type: none"> <li>• Technology</li> <li>• Retail</li> <li>• Non-profit</li> <li>• Technology</li> <li>• Media</li> <li>• Financial services</li> <li>• Agriculture</li> <li>• Education</li> </ul>	5-15%
Large (10,000+)	5	<ul style="list-style-type: none"> <li>• Benefit services</li> <li>• Oil/gas</li> <li>• Technology</li> <li>• Utilities</li> </ul>	5-20%

While the interviewees reflect a wide range of industries and company sizes, there are two possible selection biases inherent in the sample. First, interviewees that agreed to an interview were either small or large companies—no medium-sized companies (1,000-10,000) are represented in the sample. There is no reason to expect that medium-sized companies’ responses would differ greatly from the small and large companies interviewed, however it is worth noting the lack of this size company in our sample.

Also, the majority of industries represented in the sample are considered white-collar industries, which are known to have fewer smokers than blue-collar employers. Labor unions frequently represent the interests of blue-collar workers, particularly in the areas of benefits. We were unable to include a labor union in our sample, so this viewpoint is not completely represented in the survey. This is a population worth investigating in future Alliance work.

All interviews followed an interview guide created by the California Tobacco Control Alliance, with all interviewees receiving the guide in advance. (See the interview guide at Appendix B). The key areas of questioning during the interviews were:

1. Organizational information
2. Benefit selection process
3. Current benefits
4. Smoking cessation benefits
5. Benefit communications

Survey findings are detailed in the following pages.

### **Benefit selection process**

#### *Logistics*

The majority of employers (10 out of 15) perform a benefits review every year. The review is done at the same time each year, and can take from several weeks to several months to perform. Large companies were more likely to review benefits every two or three years; small companies more commonly reviewed benefits each year.

The decision-making process normally included a group of people. Most commonly the group included a senior human resources executive (Manager and/or Director) with support staff. Over half of the time (7 out of 15 companies), this group also included an insurance broker. After the initial meetings, the group normally presented a proposed benefits package to executive leadership, such as a company CFO or COO, for approval.

*Critical decision factors*

Employers were presented with a list of factors that may influence their decisions about benefits selection. The factors included employee demand, benefit cost, condition cost, condition prevalence, media visibility, company good will and company belief system about the condition.

By far the two most important factors were benefit cost and employee demand. Of the 15 companies interviewed, eight considered benefit cost the most important factor, four ranked employee demand the highest, and two companies ranked cost and demand equally. Eleven out of 15 companies ranked employee demand and cost as their top two choices. The next most important factor was the condition cost, with five out of 15 ranking it as one of their top three factors. A total of eight companies only selected their top one or two factors, stating that the other factors did not affect their benefit selection process. Table 2 summarizes the ranking of all factors by employers.

**Table 2 Ranking of factors in benefits decision-making**

Factor	Companies ranking of factors		
	Rank #1	Rank #2	Rank #3
<b>Employee demand</b>	4	5	-
<b>Benefit cost</b>	8	3	1
<b>Condition cost</b>	-	2	3
<b>Condition prevalence</b>	-	-	2
<b>Media visibility</b>	-	-	-
<b>Company goodwill</b>	-	-	1
<b>Belief system about condition</b>	-	-	-
<b>Ranked more than 1 factor equally</b>	3	1	
<b>Did not rank</b>	-	4	8

### **Current Medical/Health Benefits**

All employers offered a standard medical-dental-vision package, with most companies also supplementing the package with benefits such as life insurance, 401(k) plans, drug and alcohol treatment, and chiropractic coverage. Of the companies interviewed, six offer benefits to all employees, and nine provide benefits to part-time employees that work a minimum number of hours.

Employers were asked if they offered preventive health benefits, incentive programs or worksite wellness programs. Preventive health benefits were defined as medical benefits for preventive services. Incentive programs were defined as offering an incentive to employees to either give up an unhealthy habit, or practice a healthy one. Worksite wellness programs were defined as health promotion programs implemented company-wide and offered to all employees.

Two companies offered a “100% preventive care benefit” to all employees, and one offered a preventive wellness benefit through its HMOs; all of these companies were large companies. One company noted that their health plans may offer some preventive coverage, but the interviewee was not familiar enough with the benefit package to provide more detail. The remaining 11 companies did not offer coverage for preventive health services.

Incentive programs were offered at two companies. Incentives were typically small gifts such as a lunch gift certificate for completing a Health Risk Assessment, or for participating in an annual employee wellness campaign. Eight companies offered worksite wellness programs, such as fitness centers, flu shots and weight watchers programs. Three companies noted that they had previously offered preventive health

programs and subsequently eliminated them, either due to financial pressures or difficulties in administering the program.

**Existing smoking cessation benefit programs**

Employers were asked to provide their own definition of a smoking cessation benefit. While the Alliance has defined a “model” smoking cessation benefit (See Appendix C), which includes brief cessation intervention, medication and intensive behavioral treatment, no prompts or sample benefit components were provided to the interviewees as they created their own definition.

It is interesting to note that while four companies stated that they had never heard of a smoking cessation benefit, and most companies were reluctant to provide a definition because of their lack of knowledge in the area, five of the interviewees intuitively suggested that a benefit should contain both medication and counseling, two key benefit components according to the Alliance’s model benefit. The interviewees spontaneously and creatively developed their own definitions, and several of the same components were brought up by a number of companies. These definitions should be considered in the Alliance’s ongoing work as they may indicate the types of benefits employers are willing to implement. The benefit components provided by employers are summarized below.

**Table 3 Employer defined smoking cessation benefits**

<b>Benefit component</b>	<b>Number of respondents including component in their definition</b>
Counseling plus medications	5
Help to quit smoking	5
Different benefits for smokers vs. non-smokers	1
Incentives for people to stop smoking	3
Report back to employers on results	2
On-site facilitator; part of worksite wellness	1
<i>Never heard of smoking cessation benefits</i>	4

None of the companies interviewed currently offered a comprehensive smoking cessation benefit to their employees, although two had offered benefits in the past. One company noted that one of their health plans offered an incentive to stop smoking, and three believed that there were some resources offered through health plans.

Companies gave several reasons for not offering smoking cessation benefits to employees. Four companies believed that smoking was not a serious health issue at their company, and therefore did not merit adding a benefit. Two companies noted that making changes to benefits was done very conservatively; making too many changes may send a “negative message” to employees. For one company that had offered the benefit in the past, they had found there to be a lack of enthusiasm for and participation in the program. When faced with budget cuts, they had eliminated the benefit.

When asked if they were satisfied with the level of smoking cessation benefits, one company was not, and seven companies stated that they were satisfied with the level of benefits. The company that was not satisfied did not offer a benefit; the interviewee believed the benefit should be offered, and therefore was not satisfied. The companies that were satisfied gave several reasons. One stated that they already offered worksite wellness programs related to smoking, so did not need to add a benefit. Four companies stated that smoking was not a problem, as evidenced by the fact that employees had never asked for this benefit.

Seven companies were unsure if their cessation benefits were adequate. Some had never heard of this type of benefit and were interested in obtaining more information. Others were in the midst of reshaping their wellness and prevention programs and were receptive to investigating this issue more. These companies, and others like them, could

be receptive targets for the Alliance's educational messages about smoking cessation benefits.

### **Benefit communications**

Companies were asked about means of communicating benefits information with health plans, employees and outside entities. The preferred method of communication with health plans was via email or with a specific contact at the health plan. Seven companies did all or most of their communications with health plans through a broker. Communicating with employees about benefits was always done in multiple ways in order to reach all employees effectively. The most common methods were email, direct mail and the company intranet. Communication about benefits is most likely to occur at open enrollment periods, or once per year.

Companies that were interested in adding new benefits needed certain information in order to make their case. The most common need of employers was return-on-investment and cost information. Nine companies stated that they needed a concrete demonstration of cost savings and thorough outline of benefit costs, in order to add any new benefit. Employee demand was also an important consideration, with six companies stating that this was the primary driver in adding new benefits. Other needs were program effectiveness (two companies) and information about what competitors were offering to employees (two companies).

### **Barriers to implementation**

While implementing smoking cessation benefits can be an effective means of improving employee health, employers face sizable barriers in doing so. The barriers fall

into four main categories: cost, knowledge gap, nature of smoking and employee communication. The barriers are outlined below:

- Cost: The current economic climate combined with four consecutive years of double-digit healthcare cost increases<sup>5</sup> has reduced employer willingness to add new benefits to existing packages. At this time, most employers are facing very difficult cost-cutting decisions, such as raising deductibles or increasing employee share of premium payments. Employers' current mindset simply does not accommodate adding a new benefit—particularly one that is perceived as an “extra” that will only benefit a small portion of the workforce.

When selecting benefits, employers are typically focused on short-term cost savings, and are skeptical about the ability for condition-specific benefits or programs to generate these savings. Even current high-visibility conditions such as diabetes and obesity are not a priority to employers—they are focused on the short-term, rather than the long-term cost returns typically associated with disease-specific benefits.

- Knowledge gap Our survey revealed that many employers might not perceive smoking as a significant health issue for their workforce, and they have limited awareness about smoking cessation benefits. Several employers mentioned that smoking was “not a problem” for their employees, yet it is known that over 16% of the state population smokes. In addition to being unaware of the severity of the problem within their company, many companies do not have a thorough understanding of cessation benefits. In fact, over one-quarter of the companies surveyed had never heard of a smoking cessation benefit.

- Nature of smoking It is notoriously difficult to give up smoking. Employers who offer cessation benefits may be required to offer an employee support multiple times over the course of their employment. Offering this kind of support requires a long-term treatment strategy, and an understanding of the complexities of human behavior change. Employers, who are currently focused on short-term returns, may not be capable of making this transition in thinking.
- Employee communication Several companies (six out of 15) mentioned that smoking was not a health issue in their company and that employees were not asking for cessation benefits. However, in a statewide survey conducted by the Survey and Policy Research Institute at San Jose State University in November 2003<sup>6</sup>, Californians with health insurance indicated that they want and are willing to pay for smoking cessation benefits. This suggests a communication gap between employers and employees around employees' need for cessation benefits. It is possible that employees are concerned about repercussions from their employer should they ask for assistance with an issue such as smoking. Smoking can be a contentious issue with employers due to lost work time because of smoking breaks, increased absences for smokers, and higher healthcare costs related to smoking, and employees who need help may not ask for it due to concerns about their job security.

### **Recommendations**

The survey revealed that employers might not be immediately receptive or amenable to investing in cessation benefits. However, there are avenues of communication to explore that may increase their interest and willingness to invest in

cessation programs. One important strategy is to increase employer awareness of both the nature of the problem and the available solutions. As the largest problem in the employers' mind is usually related to cost, creating a sound business case for distribution to employers should be the first step.

*Building a business case*

Almost every employer interviewed (nine out of 15) stated the need for a solid and compelling business case and ROI analysis. Given the current business climate, employers are extremely sensitive to adding new healthcare costs. Employers are also extremely sophisticated and detail-focused—when calculating costs for their workforce, they are not satisfied with general estimates of costs and cost savings. Employers need “hard” numbers that are specific to their own workforce, considering the number of employees that smoke at their company and how much the company is currently paying in health care costs for these smokers. Employers are focused on short-term cost savings, so any return-on-investment analysis would have to demonstrate an early return on investment.

The Alliance has already performed substantial work in this area, and only minimal effort is required to assemble the various pieces of analysis into a cogent business case. The greater challenge is gaining access to employers so as to deliver their message.

Employers, and especially human resources personnel, are notoriously difficult to access from the outside. To get around this hurdle, the Alliance can use three access points to gain an audience with the employer: employees, labor unions and brokers.

*Enlisting employees*

Survey results show that employee needs and opinions count when selecting benefits. As previously noted, employers rank employee demand as one of the most important decision-making factors when selecting benefits. This survey however revealed a significant communication gap between employers and employees. While an earlier survey showed that smoking cessation benefits are important to employees, employers say that this benefit is not of interest to their workforce.

Employees may not be speaking directly to employers about smoking cessation because of privacy concerns, or fear of jeopardizing their jobs should they admit to needing support in this area. It is also possible that employees do not know that this type of benefit exists; during this survey four out of 15 employers stated that they had never heard of a cessation benefit.

Employees should be utilized as a marketing tool to access employers. Directly marketing to employees on the benefits and costs of smoking cessation benefits can result in greater awareness and thus greater demand.

*Utilizing labor unions*

It is well known that class-based disparities exist in tobacco use<sup>7</sup>. Blue-collar workers are more likely to smoke, tend to smoke more heavily, and are less successful in quitting than white-collar or service workers. A potential avenue for expanding cessation benefits is collaboration with labor unions. Unions are likely to represent at-risk workers, offer health insurance plans to their members, and advocate for the rights of their membership. Partnering with labor unions may be a successful means of reaching this population, and promoting the need for cessation benefits.

While no labor unions were interviewed for this survey, in 2001 a survey was conducted of a labor-management fund regarding the level of insurance coverage for smoking cessation treatment. Less than one-third of administrators interviewed reported that their funds covered any kind of smoking cessation services, but funds who reported receiving a request from members for cessation services were much more likely to provide those services. This willingness to listen to members, and act on requests can be a leverage point for the Alliance's current efforts.

*Insurance brokers*

Almost half (seven out of 15) of the companies interviewed report using an insurance broker. Brokers can be used to identify appropriate benefits packages, communicate with health plans, and assist in negotiating benefits packages. Companies frequently use brokers to provide expertise that they may not have internally—this is especially true for smaller companies with a small human resources department.

A broker can be utilized to influence a company's decision about benefits. Many employers rely on brokers to educate them about benefit options, and facilitate decision-making. Should a broker provide relevant information to an employer, it may be met with a better reception than an outside organization unknown to the employer.

**Conclusion**

This survey demonstrated the sizable gaps in coverage for smoking cessation at California employers. While employers do not appear to consider smoking cessation a high health priority, rising health costs associated with smoking indicated otherwise. The effectiveness of offering a benefit to induce smokers to quit, coupled with expressed

employee demand for this type of benefit, offer compelling motivation for employers to offer the benefit.

To convince employers of the need for cessation benefits, barriers around cost must be overcome. Employers stated repeatedly the need for a convincing, realistic business case. This business case must include concrete demonstration of cost savings, effectiveness of treatment and evidence of employee demand. This information does exist—the true hurdle is bringing the case to an employer and “selling” to a sophisticated and somewhat cynical audience.

Several avenues may be pursued to perform this marketing. First, employees have already expressed the desire and need for cessation benefits. Marketing a benefit directly to employees may successfully serve as a means of increasing demand. Second, engaging in further dialogue with labor unions to educate them on cessation benefits, may in turn lead to increased demand on the part of labor, who has a vocal, powerful presence with California employers. Finally, utilizing insurance brokers to deliver the message to employers may be an effective means of reaching the intended audience. In order to reach the employer to deliver the message, it is worthwhile to investigate each of these methods.

**Appendix A: Survey Participants**

A sample of the companies interviewed is below. Note that some companies requested that their names be kept confidential.

<b>Company</b>	<b>Employees</b>	<b>Industry</b>
Brown & Toland	225	Healthcare
CalPERS	1,200,000 beneficiaries	Benefit services
Capitol Public Radio	50	Media
ChevronTexaco	54,400	Oil
Douglas Emmet	380	Financial services
Hill Physicians	330	Healthcare
Lendors First Choice	160	Financial services
Oracle	8,000	Technology
Pacific Coast Producers	200	Agriculture
Robbins Brothers	350	Retail
San Rafael City Schools	525	Education
SBC	39,000	Utilities
Totality	155	Technology

**Appendix B: Interview Guide**

Category	Question
<b>Organization</b>	1. What is your role within the company?
	2. How many employees do you have in California?
	3. Is California your primary location? If not, please list other locations.
	4. How many smokers would you estimate work at your company?
	5. Describe the human resources function at your company (i.e. size, location in company, internal vs. TPA etc.).
<b>Benefit selection process</b>	6. Describe your benefits selection process:
	a. Participants in process (internal and external)
	b. Decision cycle (length, frequency, etc.)
	c. Factors considered when selecting benefits
	7. Rank the following factors as most to least likely to influence your decision making about purchasing a specific benefit:
	a. Employee demand
	b. Cost of benefit (i.e. what price point is too high?)
	c. Cost of related condition to company (i.e. medical costs, absenteeism, other)
	d. Prevalence of certain condition in company (i.e. what rate would make you decide to purchase?)
	e. Visibility in media
f. Company goodwill	
g. Belief system about condition	
<b>Current benefits</b>	8. Are all employees at your company offered benefits?
	9. What benefits are offered (medical, dental, vision, etc.)?
	10. Does your company currently offer any preventive health programs:
	a. Benefits? If yes, please describe.
	b. Incentive programs? If yes, please describe.
	c. Worksite wellness? If yes, please describe.
	11. If your company provided any of the programs listed in Question 10, but subsequently chose to eliminate them, please describe factors leading to this decision.
<b>Smoking cessation benefits</b>	12. How do you define a smoking cessation benefit?
	13. Have you ever offered a smoking cessation benefit to employees?
	a. If yes, please describe
	b. If no, what factors prevented you from offering the benefit? Did you choose something in lieu of the smoking cessation benefit?

<b>Category</b>	<b>Question</b>
	14. Are you satisfied with your current smoking cessation benefits?
<b>I. Health plan communications</b>	15. What is the best method of disseminating benefit information at your company?
	a. From your company to health plans?
	b. From health plans to your company?
	c. From your company to employees?
	d. From external organizations, such as advocacy/policy groups, to your company?
	16. If you want to advocate for smoking cessation benefits with health plans, what types of support or resources do you need?

## **Appendix C Proposed Model Smoking Cessation Benefit**

### **What is Covered?**

1. Brief cessation intervention by physician and clinical staff consisting of all of the 5 “A’s” (Ask, Advise, Assess, Assist, Arrange).
2. First line pharmacotherapy drugs, both OTC and prescription, including:
  - Prescription
  - Bupropion SR (Zyban)
  - Nicotine nasal spray
  - Nicotine inhaler
  - Nicotine patches still listed as Rx only (i.e. Havitrol)
  
  - Over-the-Counter
  - Nicotine patch (i.e. Nicoderm)
  - Nicotine gum (i.e. Nicorette)
  - Nicotine lozenge (i.e. Commit)
3. Second Line pharmacotherapy drugs (for use after first line have been considered or used)
  - Prescription
  - Clonidine
  - Nortriptyline
4. Intensive, timely, person-to-person behavioral treatment, by trained cessation specialists.  
The format for cessation sessions may consist of group, telephone, or individual face-to-face interventions.

### **Who will receive this new benefit?**

All enrollees in California health plans, under either commercial or Medi-Cal products.

### **What will the enrollee costs be?**

1. For visits to primary care physicians or trained cessation specialists, specifically to discuss quitting smoking, health impacts, available options, and strategies for success -- co-payments will be equal to the standard co-payment required for office visits.
2. For pharmacotherapies -- co-payments will be consistent with the enrollee’s pharmacy benefit.
3. For participation in plan-sponsored, medical group-sponsored or community-sponsored classes or groups – except for Medi-Cal enrollees, the health plan may require some co-pay or share of cost from the enrollee.

### **What limits will be placed on use of the smoking cessation benefit?**

1. Two courses of treatment will be covered per year.
2. Participation in a range of behavioral treatment options (see #4, “What is Covered?”) will be a condition for receipt of medications.
3. Repeated quit attempts will be unrestricted, with the exception that courses of medication will be capped at two courses per year. Enrollees may participate in an unlimited number of cessation classes, group programs, behavioral treatment sessions or visits with a trained cessation specialist in a year. Co-pays or share of cost requirements may apply to repeat use of behavioral treatments.
4. Cessation visits, behavioral treatment sessions, and pharmacotherapy services are separate from the mental health benefit and will not be counted against it.

## **Literature**

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<sup>1</sup> California Department of Health Services. California Tobacco Survey: 2002.

<sup>2</sup> Centers for Disease Control and Prevention, Department of Health and Human Services, “Coverage for Tobacco Use Cessation Treatments: Why, What, and How”.

<sup>3</sup> California Tobacco Control Alliance, “Smoking Cessation Benefits Everyone”, <http://www.cessationbenefitseveryone.org/LearnMore.htm>.

<sup>4</sup> Per actuarial analysis performed by Buck Consulting in 2003, commissioned by the California Tobacco Control Alliance.

<sup>5</sup> Agency for Healthcare Quality and Research, <http://www.ahrq.gov/news/ulp/costs/ulpcosts1.htm>.

<sup>6</sup> Per survey performed by Survey and Policy Research Institute at San Jose State University in 2003, commissioned by the California Tobacco Control Alliance.

<sup>7</sup> Barbeau EM et al. Coverage of smoking cessation treatment by union health and welfare funds. *American Journal of Public Health*. 2001. 91(5):1412-1415.