

Influencing Taft–Hartley Funds to Provide Tobacco Cessation Benefits

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Background: Taft–Hartley Health and Welfare Funds (“funds”) administer health insurance plans that cover approximately nine million U.S. adults. Unionized workers covered by funds work primarily in blue- and pink-collar occupations and smoke at a rate almost twice that of workers in other occupations. Most funds do not provide comprehensive coverage for tobacco cessation treatment for fund participants (workers, family members, and retirees).

Purpose: This study tested a pilot intervention to increase the provision and promotion of cessation benefits among Minnesota-based funds by educating the funds’ advisors.

Methods: Tailored educational outreach was conducted to advisors (administrators, consultants, attorneys) of 10 Minnesota-based funds (2009–2011). Pre- and post-intervention advisor interviews measured perceptions/knowledge/attitudes about tobacco use, cessation, coverage, and promotion of benefits. Pre- and post-intervention data on benefit provision were collected from Summary Plan Descriptions (SPDs) and Summary Material Modifications (SMMs) of 10 Minnesota-based funds and 19 comparison funds in Massachusetts and Washington, and compared in 2011. SPDs/SMMs were scored on benefit adequacy, comparing services covered and the extent to which they met DHHS recommendations.

Results: Minnesota-based funds provided significantly higher coverage (except for copays and pre-conditions) pre-intervention. However, there were no significant differences between Minnesota and comparison funds in rate of improvement in benefits over time. At follow-up, advisors reported a significant increase in confidence in their knowledge to address smoking issues in funds. Advisors also reported sharing intervention information with fund trustees.

Conclusions: Educational strategies to influence advisors who provide guidance to fund trustees may help to increase advisors’ confidence to address cessation benefit improvement.

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Introduction

Taft–Hartley Health and Welfare Funds (“funds”) provide healthcare benefits to private sector, unionized workers, families, and retirees (participants), including roughly one fifth of all U.S. adult smokers, under the Labor Management Relations Act of 1947

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(Taft–Hartley Act).^{1,2} Each fund is administered by a board of trustees with equal labor/management representation.² As fiduciaries, trustees must select appropriate benefits affecting participants, while safeguarding fund assets. Trustees often lack knowledge about healthcare benefits and/or cost analyses,³ and seek decision-making guidance from advisors (administrators, consultants, attorneys), who themselves often lack expertise regarding healthcare prevention, coverage, and promotion, including tobacco-related imperatives.^{3–5}

The prevalence of smoking among U.S. adult workers in the building trades and food services/accommodations is about 30%, compared to 19.3% among all adults.⁶ Reducing smokers’ treatment costs is important: Lower treatment costs are associated with a greater likelihood of abstinence.⁷ The clinical practice guideline for cessation treatment recommends covering U.S. Food and Drug

Administration (FDA)–approved over-the-counter (OTC) prescription cessation medications and counseling as fully paid benefits, without deductibles.⁸ In contrast, most funds impose cost limits, limit medications, cap the number of covered quit attempts, and/or cover only workers, not dependents.

The present study tested strategies to improve fund-administered cessation benefits through a 24-month educational outreach intervention (April 2009–March 2011) to increase advisors' knowledge about recommended benefits for tobacco cessation and improve their view of their effectiveness. It was hoped that advisors would recommend benefit changes to fund trustees and that these recommendations would result in benefit improvement.

Methods

Using a purchased database, 45 Minnesota-based funds were identified and ten were selected to achieve a mix of industries/occupations and fund sizes, based on total workers and size of

assets. Selection criteria for the comparison states of Massachusetts (ten) and Washington (nine) included workforce size, workforce percentage represented by unions, unemployment rate, and comparable mix of industry/occupation-specific funds and labor unions.

Researchers contacted the advisors of the ten selected Minnesota-based funds to request participation; 19 of 22 advisors of these funds agreed (11 administrators, five attorneys, three consultants). These advisors received a five-component intervention:

1. **Events:** Advisors were invited to two events (luncheon/breakfast), featuring speakers with relevant expertise.
2. **Tailored meetings:** Researchers met individually with advisors to review a selected fund's benefits, compared with a model benefit.⁸
3. **Newsletter series:** Six editions—spanning costs, savings, benefit design/promotion, wellness, and prevention—were mailed/e-mailed to advisors and posted online (publichealthlawcenter.org/programs/workshifts).
4. **Newsfeeds:** Advisors received news clips and research summaries (archived online).⁹
5. **Brainstorm sessions:** Researchers facilitated two sessions about benefit promotion.

Table 1. Cessation benefits coverage and scores

Cessation benefits coverage	Counseling (%)		OTC medications (%)		Prescription medications (%)		Dimension summary score	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Cover the service								
Intervention	80.0	100.0	70.0	90.0	60.0	100.0	0.70*	0.97*
Control	11.8	47.1	11.8	17.7	70.6	76.5	0.31	0.47
No copayment								
Intervention	80.0	100.0	70.0	90.0	30.0	10.0	0.60*	0.67*
Control	11.8	41.2	11.8	17.7	17.7	35.3	0.14	0.31
No pre-condition for medications								
Intervention			10.0	10.0	60.0	60.0	0.35	0.35
Control			64.7	64.7	52.9	58.8	0.59	0.62
No time limit								
Intervention	80.0	100.0	70.0	90.0	50.0	90.0	0.66*	0.90*
Control	11.8	41.2	5.9	17.7	41.2	52.9	0.38	0.48
No cost limit								
Intervention	80.0	100.0	60.0	80.0	50.0	70.0	0.63	0.88*
Control	64.7	41.2	58.8	17.7	11.8	52.9	0.56	0.42
Service summary score								
Intervention	3.20*	4.00*	2.80*	3.65*	2.50	3.40	2.94	3.77*
Control	1.00	1.71	1.59	1.35	2.21	2.88	1.97	2.30

Note: Boldface indicates significance. Service score: maximum for counseling=4; maximum for OTC medications=5; maximum for prescription medications=5; maximum overall score=5.

*Significantly different from control ($p < 0.05$)

OTC, over-the-counter

Summary Plan Descriptions (SPDs) and Summary Material Modifications (SMMs), describing covered benefits, were examined for intervention and comparison funds pre- and post-intervention to identify benefit changes. Additionally, Minnesota advisors were interviewed pre- and post-intervention to assess perceptions/knowledge/attitudes about coverage and promotion.

Summary Plan Descriptions/Summary Material Modifications

Researchers coded SPDs/SMMs for coverage of three cessation services: counseling, OTC medications, and prescription medica-

tions. For each service, researchers coded several dimensions of coverage to determine whether the service was covered; required copayments and/or co-insurance; imposed cost limits or time limits on coverage; and required counseling as a prerequisite for medication coverage. Each fund was assigned a yes/no score (1/0) for each service on each dimension. Two researchers coded SPDs/SMMs independently and resolved disagreements, and a third resolved remaining disagreements. Two sets of scores were calculated for each intervention and comparison fund at both time points; a service summary score averaged dimension scores within each service, and a dimension summary score averaged dimension

scores across services. An overall score summed the five dimension summary scores. A general linear model analysis, using SAS, version 9.2, was conducted in 2011 for each dimension summary score and service summary score, examining differences between intervention and comparison funds, change between baseline and follow-up measurement, and differences between intervention and comparison funds in change over time (condition X time interaction).

Interviews

Advisors were interviewed pre- and post-intervention to measure perceptions/knowledge/attitudes concerning tobacco use, dependence and cessation, and coverage and promotion of benefits. Response options about perceptions/knowledge/attitudes were 5-point Likert-type scales (strongly agree to strongly disagree). For reporting, scales were collapsed to *agree* and *disagree/neither*. Response options about coverage components were *yes/no*.

Results

Among advisors, 12 of 19 (63.16%) participated in at least one event; 17 of 19 (89.47%) in a tailored meeting; six of 19 (31.58%) in a brainstorm session; and 19 of 19 (100%) re-

Table 2. Minnesota advisor attitudes and actions: benefit provision and promotion, % agreeing

Attitude/behavior	Baseline	Follow-up
Importance/effectiveness of providing and promoting tobacco-cessation services^a		
Cessation services help people to quit smoking and stay quit	78.6	78.6
Providing cessation coverage is necessary to improve success rates for quitting smoking	85.7	100
It is the responsibility of the fund to help participants quit	85.7	71.4
Reducing tobacco use rates among participants will reduce the fund's overall healthcare costs	92.9	85.7
The fund should actively promote the cessation benefit	78.6	78.6
Components that should be covered as a benefit^a		
Over-the-counter nicotine replacement medications	78.6	100
Prescription medications	85.7	85.7
Quit smoking groups or classes	71.4	85.7
Telephone counseling	85.7	85.7
Individual in-person counseling	50.0	50.0
No limits on number of quit attempts covered	42.9	50.0
No copay and/or deductible for services	21.4	35.7
Reported use of intervention information^b		
Shared the information with fund trustees		88.2
Shared the information with colleagues		64.7
Shared the information with participants		35.3
Discussed the following ideas to promote benefits		
Placing an article in a fund or union newsletter		52.9
Promoting the benefit on union or health plan website		64.7
Including the information with SPDs/SMMs		88.2
Providing incentives to quit		70.6
Conducting quit competitions		94.1
Confidence that has the knowledge necessary to address smoking^c	41.1	76.5*

Note: Boldface indicates significance.

^aResults reflect the answers of 14 advisors who completed both the baseline and follow-up interviews.

^bResults reflect the answers of 17 advisors who completed the follow-up interviews.

^cPre-intervention confidence reported at follow-up interview.

*Significantly different from pre-intervention confidence, McNemar's test, $p=0.03$.

SMMs, Summary Material Modifications; SPDs, Summary Plan Descriptions

ceived newsletters and newsfeeds. Three advisors lived outside Minnesota and consequently could not attend in-person-only events and brainstorm sessions.

Table 1 shows the percentage of funds at each time-point that met the criteria for adequate coverage per service and dimension of coverage, and service and dimension summary scores. There were no significant increases in service and dimension summary scores post-intervention for either the intervention or the comparison funds, nor was there a condition X time interaction. Intervention funds generally scored higher than comparison funds in service summary scores ($p < 0.05$, except in prescription medications) and dimension summary scores ($p < 0.05$, except in no requirement of counseling as a pre-condition for medications).

Advisors completed interviews pre- ($n = 14$) and post-intervention ($n = 17$). Table 2 summarizes responses regarding perceptions/knowledge/attitudes about benefits at baseline and follow-up of those who completed both interviews, and summarizes advisors' use of intervention information at follow-up. There were no significant differences pre- and post-intervention in attitudes about providing and promoting cessation services or components of cessation benefits. At follow-up, advisors reported sharing benefit information they gained through project participation with colleagues and fund trustees. Additionally, at follow-up, 76.5% of advisors reported now having confidence in their knowledge to address smoking as a health issue, and 41.1% reported having confidence 2 years prior (McNemar's test, $p = 0.03$).

Discussion

Baseline comparisons between intervention and comparison funds revealed striking differences in benefit patterns: Minnesota-based funds provided significantly higher levels of coverage, with the exception of copays and pre-conditions. However, there were no significant differences between Minnesota and comparison funds regarding the rate of improvement in benefits over time. This may reflect a ceiling effect for the Minnesota funds: Because coverage was already quite high, there was little room for improvement. Also, the time frame might have been too short to register changes in benefits resulting from the intervention: Interviews with Minnesota advisors in 2006–2008 found funds make changes at a slow pace.⁵

Despite a lack of measurable impact in benefit coverage, the findings suggest that intervention components positively influenced advisors' behavior. At follow-up, advisors reported sharing study materials and resources

with trustees of funds they advised, and reported a significant increase in confidence that they had acquired knowledge to address smoking issues. Also, ten of 19 advisors (52.6%) expressed interest in working across funds to increase participants' use of benefits. Many were not convinced by the intervention to eliminate copays and pre-conditions, which are major barriers to benefit use.¹⁰ Research is needed to better understand advisors' resistance.

Limitations

Randomization of funds was not possible because advisors serve multiple funds. There was low power to detect differences between fund groups and between pre- and post-intervention measurements because of the small number of advisors and funds. Uneven intervention participation leaves uncertainty about which components influenced advisors and worked against finding a significant intervention impact.

Conclusion

The intervention improved advisors' confidence to address smoking issues with funds, despite lack of success in improving benefit coverage. More research, preferably over a longer time frame, is needed on strategies to improve coverage.

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