

Working with Business Partners: Understanding Return on Investment and Developing a Business Strategy

The 2000 Public Health Service Clinical Practice Guideline summarizes effective, evidence-based treatment for tobacco dependence. One of the recommendations is that treatment for tobacco dependence be covered as a part of health care benefits. To make the business case for smoking cessation, interventions must demonstrate that they positively affect future health care expenditures and productivity, or have a positive return on investment (ROI) for health insurance plans, employers, and other payors. The business case needs to address the health and economic consequences of tobacco use among employee groups and calculates potential cost savings (ROI) for helping tobacco users stop. Understanding ROI is an important part of working with all business partners.

What is included in a business case for tobacco cessation?

- The business case for tobacco cessation includes:
 - Costs incurred by the business by smoking employees for increased absenteeism, lost productivity, increased health care and drug costs. National estimates are that costs associated with smoking are greater than \$3700 per smoker annually.¹
 - Costs to implement a benefit for tobacco cessation services. One estimate is that the cost is \$.29 per member per month or less than \$3.50 per year. A single case of heart failure is estimated at \$5.23 per member per month or \$62.76 per year.²
 - The cost effectiveness of tobacco cessation services compared to cost effectiveness of other health benefits. Tobacco cessation services have consistently been shown to be highly cost-effect compared to other routinely reimbursed medical interventions (e.g. high blood pressure, mammograms).³
 - The potential return on investment (profit or cost savings) a business can expect from investing in tobacco cessation services. Many businesses can see a return on investment in the first year.
- Developing a business case for tobacco cessation services helps illustrate the importance of providing smoking cessation services to employees and health plan members by providing both a dollar value to these services and near-term results.

How is return on investment (ROI) calculated⁴?

Calculating an employers' economic return on adding a cessation benefit needs to be calculated separately for each business or employee group. There are many variables that will affect the results including:

- Population characteristics. For example: older employees are more likely to have health problems than younger employees. Also, lower income employees are more likely to smoke.
- Health plan type. The way a benefit is structured and how the costs are determined will depend on the type of health plan – e.g. managed care plan vs. indemnity plan.
- State/region. There are variations in smoking prevalence and in health care costs by region and these costs need to be accounted for in the ROI model.
- Disenrollment rates in health plans. Employers often negotiate health insurance contracts on an annual basis and may switch health plans based on the pricing for the benefits needed each year by their employee group. Since it takes time for the benefits of smoking cessation

to translate into reduced health care costs, the rate at which any health plan loses and gains members will influence what return on investment can be expected by a health plan implementing a cessation benefit. The health plan disenrollment rate does not affect the ROI for employers but will affect how readily a health plan offers a cessation as part of its benefit packages.

- Cessation program start-up and ongoing costs. There is always a start up cost associated with a new benefit. This will have to be paid initially while any cost savings will occur some months or years later. High start up costs can deter implementation of the cessation benefit even if the longer-term return is positive.
- Analysis period to be used. It is important to specify the time period for analysis for accurate planning.

When these data are entered into an ROI calculator, a table is produced with projected service use, projected numbers of quits, estimated costs, estimated ROI per recipient and per member per month (PM/PM) for the health plan for the selected year. (Note: Per member per month PM/PM) is the unit most often used for expressing insurance costs.)

How is the business case for health plans/insurers different from the business case for employers?

Making the business case for health plans and insurers is more challenging than for businesses for several reasons.

- There is a lack of long term (3-5 year) ROI data for health plans. The data that is available looks at near term return on investment. While the data is positive for most businesses immediately, it is not positive for health plans for 2-3 years. Longer-term data could show bigger returns over time and make a stronger case.
- Health plan data typically show a cost increase for smokers who quit but no cost increases for smokers who don't. Often health plan members who quit smoking are those who quit for immediate health reasons and are being treated for their health conditions. For example, a health plan member who quits because of a heart attack will appear in health plan data to have a significant increase in health care costs associated with quitting. Smokers who are otherwise healthy but don't quit, are not using health care services. For health plans, this appears as a negative return on investment.^{5,6,7,8}
- Employers regularly change health care coverage and individuals often change health plans. There is insufficient data to know if quitters leave a health plan before savings occur. However, smokers who are otherwise healthy and quit, are more likely to stay in a health plan than smokers who become sick before they quit. This suggests that investing in cessation services can pay off for health plans in the long term.

The business case for employers is clearer.

- The return on investment for employers is immediate. Once employees stop, their productivity increases, absenteeism is reduced, and health improves.
- Many of these employees will not have seen a health care provider for much of the illness causing their absenteeism. But, they will have been away from their jobs recovering on their own. That is why the improved health of quitters is more readily seen in business than in health care.

- Investing in both counseling and medications without co-pays for either creates the best outcome for both smokers and for business. But, providing both counseling and medication is more expensive for health plans, reducing possible ROI. Co-pays are also standard practice for health plans and insurers and help offset costs. What works best for smokers and business does not always work best for health plans, and can prevent health plans from readily offering these benefits.⁹

Using ROI in a state tobacco cessation program: Ohio case study

The state of Ohio used the ROI analysis to increase participation of businesses in a statewide initiative to promote cessation. The goals of the NRT (nicotine replacement therapy) Cooperation Plan for Ohio Businesses include 1) increasing employer awareness of the relationship between smoking cessation and wellness programs; 2) recruiting employers as cessation motivators; and 3) securing tobacco treatment resources other than limited state tobacco control program dollars. The target audience is health plans, self-insured employers and other employment-based membership groups with health responsibilities, unions and retirement systems.¹⁰

Resources to support this project come from the Ohio Tobacco Use Prevention and Control Foundation and partner organizations. The Foundation contributes NRT mail service delivery, free quitline counseling, public marketing, half of the cost of nicotine patch, evaluation and reports. The partner organization contributes half the cost of nicotine patch and marketing to members or employees.

The project was launched in July 2005. Initially four health plans representing two million covered lives participated. Since the launch, one health plan has joined. After the launch, large employers such as Goodyear and Ohio PERS contacted the project about joining. Since July 2005, Ohio Tobacco Use Prevention and Control Foundation delivered 16,000, 4-week supply of nicotine patches.

When developing the project, several questions were posed:

- What do we sell to the employer?
- What do the employers want?
- What do employers get out of the program?
- The primary message to Ohio employers was, “you cannot afford not to do this”.

Program Analysis Results

- When NRT was added to counseling services, quitline cessation quit rates substantially increased.
- Those not using NRT (counseling only) had a quit rate of 17%. Those using NRT in conjunction with counseling had a quit rate of 45%.
- The ROI for the program is:
 - A \$39 produced a \$63.16 return or a \$24.16 gain after 1 year.
 - An investment of \$39 equals \$492.12 return or \$453.12 gain after 5 years.

Additional Questions:

Q: Is there anyway to break down what the 5A's cost per client?

A: Five A's are inexpensive to deliver. Provider time costs about \$35, however, there just isn't enough time for providers to give the 10 minutes for this type of intervention.

Q: *What was the quitline cost per client in the Kaiser research study?*

A: For 5 call sessions it is about \$195 per participant. The cost for 8 weeks of NRT is \$200.

Q: *What was the cost of NRT in Ohio?*

A: For Ohio, it was \$112 for 8 weeks of NRT.

Q: *In California, we attempted to mandate this service through the Legislature. However in the political environment people challenged your findings, denied they were accurate, or simply dismissed them.*

A: The California Tobacco Control Alliance was involved with creating the numbers for reports to the Legislature. Now we are focusing on the development of manuscripts to support the model and are aiming for placement in top U.S. medical journals. The plan is to promote the model on the basis of what the underlying data shows and the impact on smoking, disease status, self-quitting, and disenrollment. We hope that publishing this model will increase its validity and acceptability.

Q: *What have your costs been in Ohio and what impact has it had on your quitline?*

A: We budgeted NRT for 1.5 million dollars. Quitline calls have jumped from 100 to 300 calls per day.

Q: *How is "end of program" defined in the Ohio evaluation?*

A: The last successfully completed counseling session.

Q: *What is the quit definition for the Ohio program?*

A: Have you used any tobacco cessation in the last 7 days?

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**For more tools & resources on making the business case visit the TCLN website:
www.tcln.org/cessation/employers**

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