An Evaluation of Health Benefit Modification in Taft–Hartley Health and Welfare Funds

Implications for Encouraging Tobacco-Cessation Coverage

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Background: An estimated one fifth of all U.S. adult smokers receive health benefits through insurance plans administered by Taft–Hartley Health and Welfare Funds. Most funds do not offer comprehensive tobacco-cessation services to fund participants despite evidence that doing so would be cost effective and save lives.

Purpose: This paper examines the decision-making processes of Minnesota-based fund trustees and advisors to identify factors that influence decisions about modifications to benefits.

Methods: Formative data about the process by which funds make health benefit modifications were collected in 2007–2008 from 25 in-depth key informant interviews with fund trustees and a cross-section of fund advisors, including administrators, attorneys, and healthcare business consultants. Analyses were performed using a general inductive approach to identify conceptual themes, employing qualitative data analysis software.

Results: The most commonly cited factors influencing trustees' decisions about health plan benefit modifications—including modifications regarding tobacco-cessation benefits—were benefit costs, participants' demand for services, and safeguarding participants' health. Barriers included information gaps, concerns about participants' response, and difficulty projecting benefit utilization and success. Advisors wielded considerable influence in decision-making processes.

Conclusions: Trustees relied on a small pool of business, legal, and administrative advisors to provide guidance and recommendations about possible health plan benefit modifications. Providing advisors with evidence-based information and resources about benefit design, cost/return-on-investment (ROI), effectiveness, and promotion may be an effective means to influence funds to provide comprehensive tobacco-cessation benefits.

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Introduction

Taft–Hartley Funds

An estimated one fifth of all U.S. adult smokers—approximately 9 million people—receive health benefits through insurance plans administered by Taft–Hartley Health and Welfare Funds ("funds").[1] The funds provide group health benefits to private-sector, unionized employees and their families under Section 302(c)(5) of the Labor Management Relations Act of 1947 (i.e., the Taft–Hartley Act). Typically, a fund is associated with one or more local affiliates of a single national or international union and is funded by contributions from companies whose employees are represented by the union. Employer contribution amounts are established in collective bargaining agreements. Funds are usually self-

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insured and provide participants with services by purchasing access to the provider networks with which private insurance companies have negotiated discounted fee arrangements.[2]

Each fund is jointly administered by a board of trustees with equal representation from labor and management. As the fiduciary of the fund, the board has the responsibility to act in the best interests of the fund's participants by making appropriate decisions about what health benefits to cover while protecting the fund's financial solvency. Trustees typically have varied backgrounds and training and often lack expertise in health benefit design and cost analyses.[3] As part of their decision-making process, trustees seek information and guidance from a small pool of advisors, including fund attorneys, actuarial and health consultants, and third-party or in-house administrators.[3–6]

Tobacco Use Among Fund Members

Most employees insured through funds are blue-collar and low-wage service workers who tend to smoke in greater percentages than do workers in white-collar occupations.[7–10] The prevalence of smoking among fund participants is estimated to be about 40%—twice the national average.[7] Treatment of tobacco-related illnesses accounts for about 10% of total healthcare costs in Taft–Hartley funds, aside from employer-incurred costs that are attributable to higher levels of absenteeism and lower productivity among workers who smoke.[11,12]

Health experts recommend coverage for tobacco-cessation treatment, including pharmacotherapy and counseling, as fully paid benefits.[13,14] Reda et al.[15] examine nine clinical trials that assess the impact of reducing the beneficiary costs of smoking cessation treatment on abstinence from smoking. The analysis reveals that full financial coverage of smoking-cessation treatment had a significant favorable effect on continuous abstinence when compared to no coverage (risk ratio [RR] 4.38; 95% CI=1.94, 9.87). Moreover, there was a significant favorable effect of full financial coverage of treatment, when compared to no coverage, on the number of participants making a quit attempt (RR 1.19; 95% CI=1.07, 1.32; n=3). Despite expert testimony and widespread evidence that covering tobacco-cessation services is effective, most funds do not offer this benefit.[1]

Fund Decisions About Benefit Design

To date, little has been done to qualitatively evaluate the process by which fund decisions are made. However, basic information on the mechanics of benefit modification by funds is available: Generally, modifications are initiated when fund participants request coverage of specific services. Trustees consider these requests, looking to their advisors for input, and vote on whether to cover the requested services.[3,4]

Research Goal

This study evaluates perspectives of trustees and advisors of Minnesota-based funds on their decision-making processes, with the goal of identifying factors that influence fund decisions about modifications to health benefits, including tobacco-cessation benefits. Insights from this evaluation can inform future efforts to encourage funds to add full coverage of tobacco-cessation treatment to their health plans.

Methods

Study Design

Members of the research team conducted 25 one-on-one, in-depth key informant interviews with Taft–Hartley trustees and advisors from January 2007 through November 2007.[16] Study procedures were approved by the University of Minnesota IRB.

Recruitment of Study Subjects

Research staff recruited study subjects using purposive snowball sampling.[17] This method enabled researchers to identify potential subjects and to obtain a sample that included equal numbers of labor and management trustees and at least three members from each advisor group (actuarial/health consultants, fund attorneys, and fund administrators). An initial list of potential study subjects was established via online research, a purchased database, and suggestions from the research team's union partners. The researchers contacted potential subjects by mail to notify them of the project and then by telephone to request participation. After each interview, study subjects were asked to identify other potential interviewees. Potential subjects were contacted using the same mail and telephone method employed previously.

Twenty-four fund trustees and 23 fund advisors were contacted as potential subjects: 15 labor trustees; nine management trustees; six third-party administrators; two in-house fund administrators; eight actuarial/health consultants; and seven fund attorneys. Ultimately, five labor trustees, six management trustees, five third-party administrators, two in-house administrators, four actuarial/health consultants, and three fund attorneys were interviewed, for a 53.2% response. The remaining people either could not be reached by phone, declined to participate, or (in four cases) were deemed ineligible because they were not affiliated with funds. The 11 trustees who participated were from the construction, manufacturing, and service sectors. The 14 advisors who participated provided guidance to one or more funds from these sectors.

Administration

The researchers developed a 16-item interview protocol for trustees and a 22-item protocol for advisors. Key questions elicited information about factors influencing fund decisions about the provision of health benefits—including tobacco-cessation benefits—and about barriers to providing coverage.

Interviews were administered by two staff members of the Public Health Law Center (PHLC) at each study participant's office and were audio-recorded. Another PHLC staff person transcribed the

recordings, which were spot-checked for accuracy. The researchers asked subjects for permission to record the interviews, assured them of the confidentiality of their responses, and instructed them to ask for clarification of any questions they did not understand.

Analysis

From January 2007 through November 2007, three members of the research team each independently analyzed a subgroup of interview transcripts, using a general inductive approach to identify conceptual themes through repeated close readings.[18] Then, the raters discussed the transcripts together, resolving and re-conceptualizing discrepancies in themes and categories until establishing a coding framework.[18,19] The coding framework consisted of major themes that emerged from study subjects' responses, and the researchers applied this framework to each transcript using the same coding process used to create the coding scheme itself, with differences resolved among the three raters.

The researchers identified two codes from the initial coding framework as particularly relevant to the present analysis: **influential factors**, which includes responses about factors influencing benefit modification decisions, in general; and **tobacco cessation**, which includes any responses involving tobacco-cessation benefits, in particular. With the aforementioned research goal as an analytic focus, two raters used the same general inductive approach described above to create a set of subcategories within each of these two primary codes to account for notable subthemes. (Themes and subcategories are listed in Table 1.) This facilitated a more precise analysis of the general factors influencing benefit modification and of the barriers to providing cessation coverage, in particular. After establishing subcategories, each rater applied these subcategories

Table 1. Subcategories of primary codes "factors" and "barriers"

Primary code: factors influencing benefit decisions	
Legal requirements and related administrative issues	Whether the fund is legally required to offer a specific benefit, whether and how the fund will have to promote the benefit to members, how the benefit will be administered (benefit structure), and anything having to do with collective bargaining
Benefit priority, fit with current benefit plan	Concerns among trustees about which benefits should take priority and whether/how a benefit fits with current benefits offered
Cost, money, return on Investment	The fiduciary responsibility of trustees: whether the fund can afford the cost of a particular benefit and whether the outcome of the benefit justifies the cost to the fund
Health, best interest of members	Whether a particular benefit is in the best interests of fund members from a health perspective
Recommendations from nontrustee advisors	Advice/recommendations from fund administrators, fund consultants, fund attorneys, and insurance service providers on what decision to make (i.e., recommendations on how to act, not simply informational or process guidance)
Medical evidence	Information about best practices regarding a benefit and the current medical research regarding the benefit's success, attendant risks, and alternatives
Personal attitudes of trustees	Trustee attitudes toward, or philosophies about, a particular benefit or health issue (for example, the idea that tobacco cessation is a personal issue, not one for the fund to deal with)
Political considerations	Concerns among trustees about re-election to the board and/or about member response to benefit modification decisions
Trends: social, industry, Taft–Hartley, medical	What other funds are doing, where social opinion is trending, and where the medical field is leaning on a particular health issue or insurance benefit
Among members: demand, motivation, needs, likely utilization	Member demand for a particular benefit, as indicated by direct contact from members, claims, claim appeals, and member health profiles
Primary code: providing cessation benefits	
Barrier: lack of information	Lack of any piece of relevant information regarding cessation services, including member demand for them, success level of cessation services, cost of tobacco-related illnesses, best practices for cessation, return on investment, and cessation services already offered by providers
Barrier: concerns about member response, ideas about proper role of fund	Concerns among trustees about the appropriate role of the fund in the lives of members, about paternalism, and about the perception among members that the fund is forcing people to quit smoking (i.e., interfering with personal choice)
Barrier: concerns about member utilization and motivation, promotion of benefit	Concerns that members will not use cessation benefits—or that, if they do use them, they will not be motivated to successfully quit—and concern about how to promote the benefit to members

to the main text of the two primary codes for all 25 interviews, later comparing their coding and reconciling discrepancies.

The researchers used NVivo 8 qualitative data analysis software to code and analyze the data. Qualitative analysis included calculations of coding proportions, word frequency analyses, examinations of phraseology, and evaluations of the conceptual frameworks of speakers' statements.[20] Counts of the number of times participants mentioned particular themes were used as a rough measure of their importance.

Results

Advisor Influence

A key finding from this evaluation is that fund advisors wield considerable influence in decision-making processes about benefit design by providing trustees with critical information and explaining to them the complexities of the insurance system. Trustees explain their reliance on advisors as a necessity: ". . . the rest of us, we're trustees, we're not fund managers, we don't want to be doing that, that's why we hire all those people." New trustees often assume their responsibilities with little prior knowledge of health insurance, compelling them to rely on their professional advisors: ". . . it is so foreign . . . the topics, the responsibility, the concepts, the system itself, is so confusing, it's so complicated." Trustees describe their relationships with fund advisors as "very close." One trustee noted, ". . . both sides [labor and management] have a lot of confidence in our professionals [advisors], that they're neutral, that they act in the best interest of our participants and provide us with very good information so that we can make good decisions." Another stressed the long-standing nature of trustee–advisor relationships: ". . . in multi-employer funds, you have to work at doing a bad job to get terminated from a fund as a consultant . . . I've been on the fund for ten years, and I think they've been with the fund about 20." Notably, trustees often expressed a preference for input from certain advisors more than others, with most citing fund administrators and attorneys as their most trusted advisors (as compared to actuarial/health consultants).

Factors Influencing Benefit Modification

Figure 1 illustrates the relative emphasis placed on ten categories of factors influencing fund decisions about benefit modification, with results presented in three respondent groupings: all respondents, trustee respondents, and advisor respondents.

When the responses of trustees and advisors are considered as a whole, cost/return-on- investment (ROI) represents by far the most prominent of the ten influential factors. Cost was alternately mentioned as *money*, *return-on-investment*, *expense*, and similar terms, with respondents acknowledging that a consideration of cost is inevitable: ". . . truly, it's based on what we can afford to do," observed one interviewee. Another stated, "It seems like more often than not it really does revert back to cost. If it's a benefit, there may be many benefits that may be great for the members but they're just impractical given the funding we have." Member utilization/demand/motivation was the next most-prominent factor in making cessation coverage decisions. One subject noted, "The next question is . . . if people [will] use it—and if they don't use it, you're not gonna find savings, and it's as simple as that." The third-most emphasized influential factor, the health of fund participants, has to do with safeguarding the well being of fund participants. One comment is illustrative: ". . . if you can provide preventative care . . . then you have to look at it and decide if that's something that if you can provide . . . you have an obligation." Finally, the factor titled **trends** (referring to social, fund, and/or industry trends in benefit coverage) followed the first three in terms of relative emphasis. Respondents

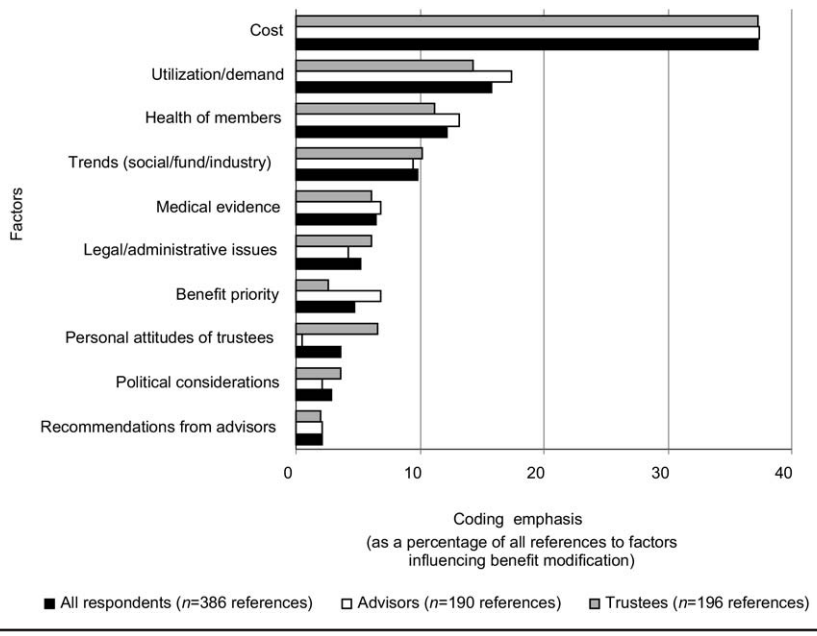

Figure 1. Factors influencing benefit modification

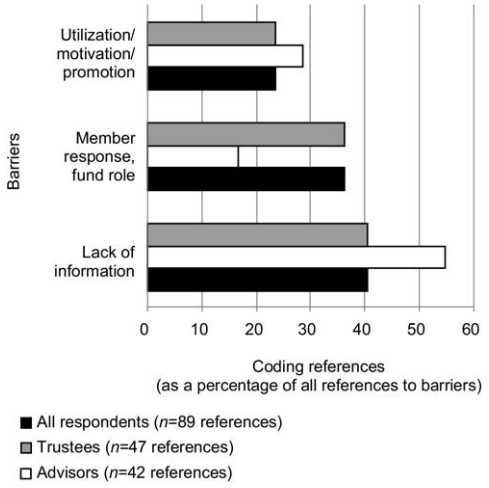

Figure 2. Barriers to providing cessation benefits

wanted to know ". . . what are other funds doing? Are they providing it? Are these funds similar in demographics to our fund?"

The results for the influential factors are the same when the analysis of factors influencing benefit modification decisions is examined according to advisor and trustee status, with small intergroup variations in relative emphasis.

Barriers to Providing Tobacco-Cessation Benefits

Figure 2 illustrates the relative emphasis placed on three barriers to providing tobacco-cessation coverage, with results again presented in three groupings: all respondents, trustee respondents, and advisor respondents. For the full group, lack of information was the most substantial barrier, comprising about half of barrier references. Information gaps included topics such as smoking prevalence among fund participants, demand for cessation benefits, and success of cessation attempts (Table 1). Respondents ultimately wanted to know things such as, ". . . if it can save us money if we get a lot of people to quit." One speaker observed, ". . . we know we spend a lot of money on this, we just don't have any idea [how much] . . . we could make a lot better decisions if we knew . . . we've got this much cost related to that." The two other barriers identified—concern that fund participants will feel that the fund is pressuring them to quit smoking (thus interfering with personal choice), and concern about benefit utilization and motivation—each accounted for about a quarter of all statements about barriers. Concern about member response to a tobacco-cessation benefit involved "what the reception would be amongst members if [the fund] were to provide that benefit . . . because a benefit is not perceived as a benefit unless someone gets something from it." One respondent offered, ". . . there's some people with some pretty strong opinions in this union about, you know, you mind your own business. I'll do what I want. I'm paying for that insurance." Finally, benefit utilization and member motivation concerns involved worries "that you spend the money on it [cessation coverage] and nobody takes advantage of it, unfortunately."

Substantial differences exist between advisors and trustees in perception of barriers to providing cessation services. While a lack of information was mentioned most often by both groups, there was a sizeable gap between advisors and trustees with respect to the relative emphasis placed on information deficits. For advisors, lack of information represented more than half of barrier references and was cited almost twice as often as the next most commonly mentioned advisor barrier—benefit utilization and member motivation. In contrast, lack of information was mentioned by trustees just slightly more often than concerns about fund participants' response. Additionally, while trustees gave fund participants' response nearly the same emphasis as informational deficits, participant response was by far the least-mentioned barrier for advisors, accounting for about half as many advisor references as the issue of benefit utilization and member motivation. For trustees, on the other hand, concern about benefit utilization and member motivation was the least-emphasized barrier, representing about one quarter of their barrier references.

Discussion

Trustees reported relying heavily on advisors for informational and process guidance when considering benefit modification. When asked about factors that influence the outcome of benefit decisions, trustees and advisors placed the same relative emphasis on which factors carried the greatest weight, stressing (in descending order of influence) cost/ROI, fund participants' utilization/demand/motivation, the health of fund participants, and social, fund, and/or industry trends in benefit coverage. Advisors and trustees identified three types of barriers to providing cessation coverage: informational deficits, concern about negative response among fund participants, and concern about benefit utilization and member motivation. However, the relative emphasis placed on these barriers differed between the two groups.

The barrier entitled **lack of information** refers to not having convenient access to information (reliable, evidence-based, timely, or otherwise) about issues related to cessation benefits. This study found that the information trustees deem influential when making decisions about benefit changes is the very information they are missing with respect to tobacco-cessation benefits. Lack of infor-

mation about cost/ROI is especially important, given that both trustees and advisors cite cost/ROI as the primary factor influencing benefit modification. Given trustees' reliance on their advisors to provide them with guidance and recommendations about benefit modifications, an effective means of influencing funds to provide cessation benefits may be to provide fund advisors with convenient access to reliable, current, evidence-based information and resources about cessation coverage. This information would include cost-related issues, including ROI, benefit design, best practices, and treatment success. In doing so, information should be framed to address trustees' sensitivity about eliciting negative reactions from fund participants, some of whom may consider a fund to be overstepping its bounds by providing cessation coverage.

As noted previously, literature about benefit modification (including tobacco-cessation benefits) in Taft–Hartley funds is sparse. However, the findings of this study are supported by the limited literature available about decisions by employers, in general, to purchase coverage for tobacco- cessation treatment. Woolf et al.,[21] for example, investigated the content and sources of information that influenced state employers when deciding whether to provide coverage for smoking-cessation treatment. Those who provided such coverage reported a heavy reliance on professional advisors (i.e., benefit consultants, actuaries, and third-party administrators) as sources of influential information in making this decision. Among states that did not provide cessation coverage, employers identified different advisors as influential (i.e., their staff and medical advisors); however, the general importance of advisors in the decision-making process supports the findings of the current paper. The authors also identified types of information that state employers considered influential, including: regional norms, cost effectiveness, treatment efficacy, employee welfare, and health management. These categories correspond closely with several of the influential factors identified in the present study.

Limitations

One limitation of this study is that there was no comprehensive sampling frame available from which to select interview subjects. Exhaustive lists of trustees and advisors of Minnesota funds did not exist: participants were chosen via nonprobability purposive snowball sampling. Therefore, study participants' opinions might not represent those of all fund advisors. A second limitation is the possibility that interviewees felt pressured by the supposed views of the interviewers to support particular positions. To minimize this effect, participants were assured that their statements would be confidential and cited only without attribution.

Conclusion

The high incidence of smoking among populations served by Taft–Hartley Health and Welfare Funds, coupled with substantial evidence of the cost effectiveness of providing tobacco-cessation coverage, indicate that it is in the best interests of funds to provide tobacco-cessation services to fund participants as a fully paid benefit—doing so would save lives and money. However, concerns about cost/ROI, deficits in knowledge about tobacco-cessation benefits, deficits in access to information, and perceptions among trustees that some fund participants may react negatively to a fund's provision of cessation services, constitute substantial barriers to the addition or improvement of cessation coverage.

Relationships between trustees and advisors are often decades-long—funds typically place a high degree of trust in these relationships and change advisors infrequently. Because trustees rely heavily on their advisors for guidance and the two groups are in general agreement about many relevant factors and barriers in the benefit modification process, streaming cost-related information (such as ROI, benefit design, best practices, and success levels) to trustees through advisors would likely be an effective strategy to encourage funds to provide tobacco-cessation benefits. Moreover, since most advisors work with multiple funds, streaming information through them holds promise as both an effective and an efficient means of dissemination. Research to test the strategy of streaming information to trustees through advisors—with fund adoption or improvement of cessation benefits as an indicator of success—is needed.

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