Access Health CT

Health Plan Benefits & Qualifications (HPBQ) Advisory Committee

December 13, 2017

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Today's Agenda

A. Call to Order and Introductions
B. Public Comment
C. Vote: November 29, 2017 Meeting Minutes
D. Certification Requirements
    - Certification Review Schedule
    - Standardized Plan Designs for 2019 (Vote if necessary)
    - Follow-Ups from Previous Meetings
        - Non-Standard Silver Plans in Individual Market (Vote if necessary)
        - Lowest Cost Silver Plan in Individual Market (Vote if necessary)
    - Tobacco Surcharge
    - Broker Compensation
    - Certification Requirements Policy
E. Next Steps
F. Adjournment

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Public Comment

(2 Minutes per Commenter)

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➢ Vote

- November 29, 2017 Meeting Minutes

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- **Certification Requirements**

Certification Review Schedule

Certification Review Topics	2017/2018 Discussion Date	Status
Requirement to submit Standardized Plan Designs	September & October	Completed
Plan Mix (Standard/Non-Standard Plan Offerings)	*September & October*	*Outstanding Items*
Pediatric Dental Coverage in Medical Plans	*September & October*	*Deferred to 12/13/17*
Lowest Cost Silver Plan in the Individual Market	*September & October*	*Pending additional review*
Essential Health Benefits (EHB) Benchmark Plan	November	Completed
Prescription Drug Formulary Standards	November	
Network Adequacy Standards	November	
Essential Community Provider (ECP) Contracting Standards	November	
Tobacco Surcharge	*December*	*Scheduled (12/13/17)*
Broker Compensation	*December*	
Certification Requirements Policy	*December - January*	*Scheduled (12/13/17, 1/10/18)*
Standardized Plan Development - Medical	*December – February*	Scheduled (12/13/17, 1/10/18, 2/7/18)
Plan Mix – Stand-Alone Dental Plans (SADPs)	January - February	Scheduled (1/10/18, 2/7/18)
Standardized Plan Development – SADP	January - February	

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➢Standardized Plans for 2019

Wakely

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2019 Individual Market Standard Plan Designs

December 13, 2017

PRESENTED BY

Julie Andrews, FSA, MAAA – Sr. Consulting Actuary

Brittney Phillips, ASA, MAAA – Consulting Actuary

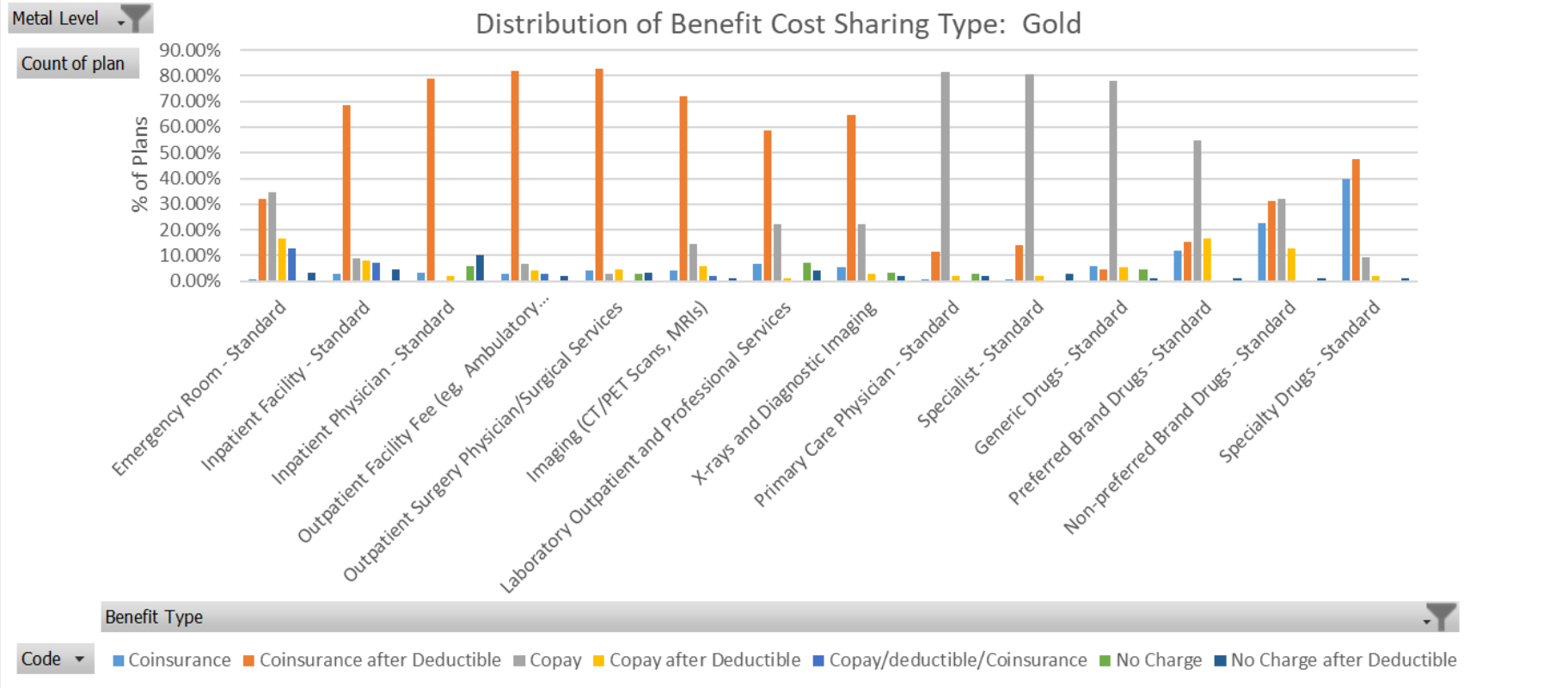
Agenda

1. 2018 Plan Overview
2. 2019 Plan Design Review
   - Regulatory Changes
   - Federal AVC Changes
   - Notes and Caveats
   - Maximum Copays
   - Summary of Proposed Changes
   - Proposed Plan Designs

2018 Plan Overview

Marketplace Review: 2018 Benefits & Cost Sharing

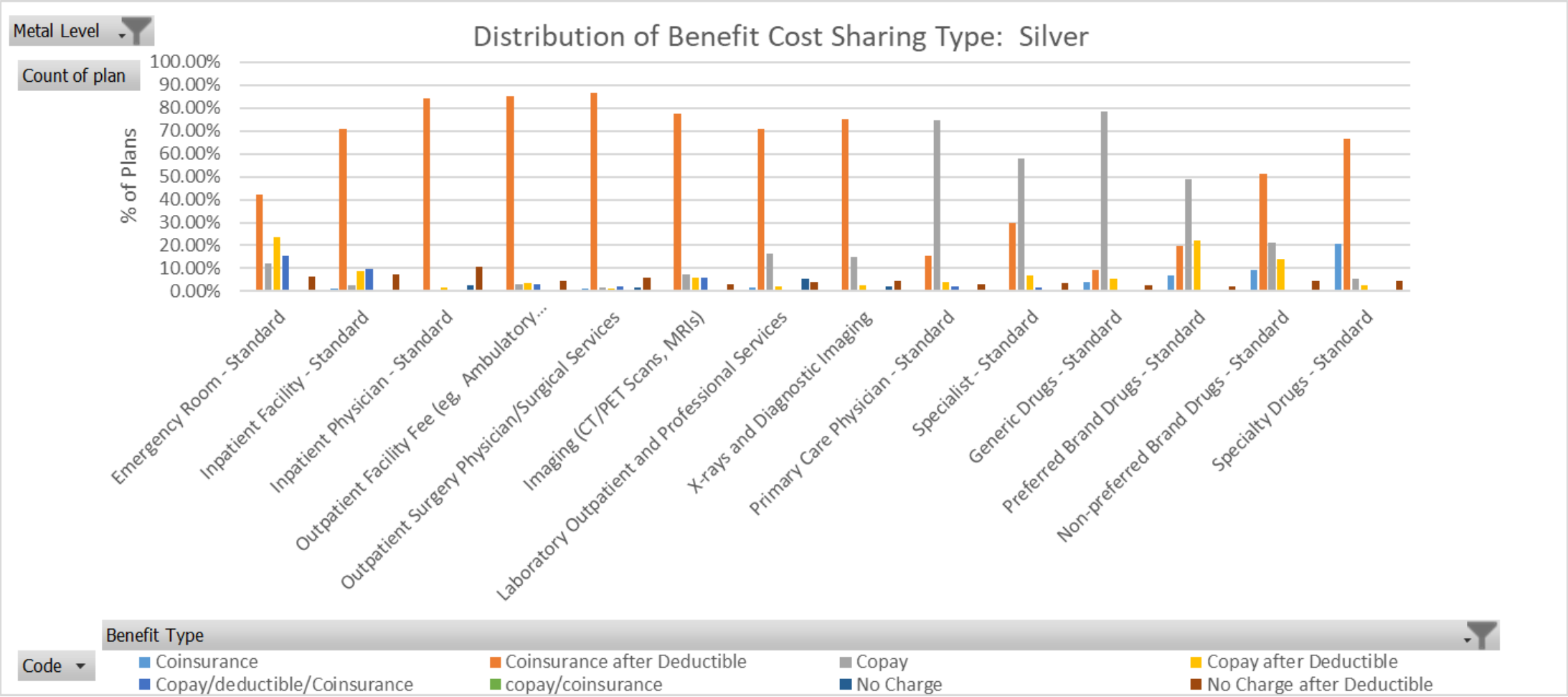
- Summary of 39 state Federal Exchange and Partnership plan offerings
- Comparison of unique plan combinations based on key service categories from AV Calculator
  - Excluded plans labeled as HSA
  - If a tiered network, Tier 1 detail presented



Source Files:
https://data.healthcare.gov/dataset/QHP-PY2018-Medi-Indi-Land/hd64-a3rh
https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html#

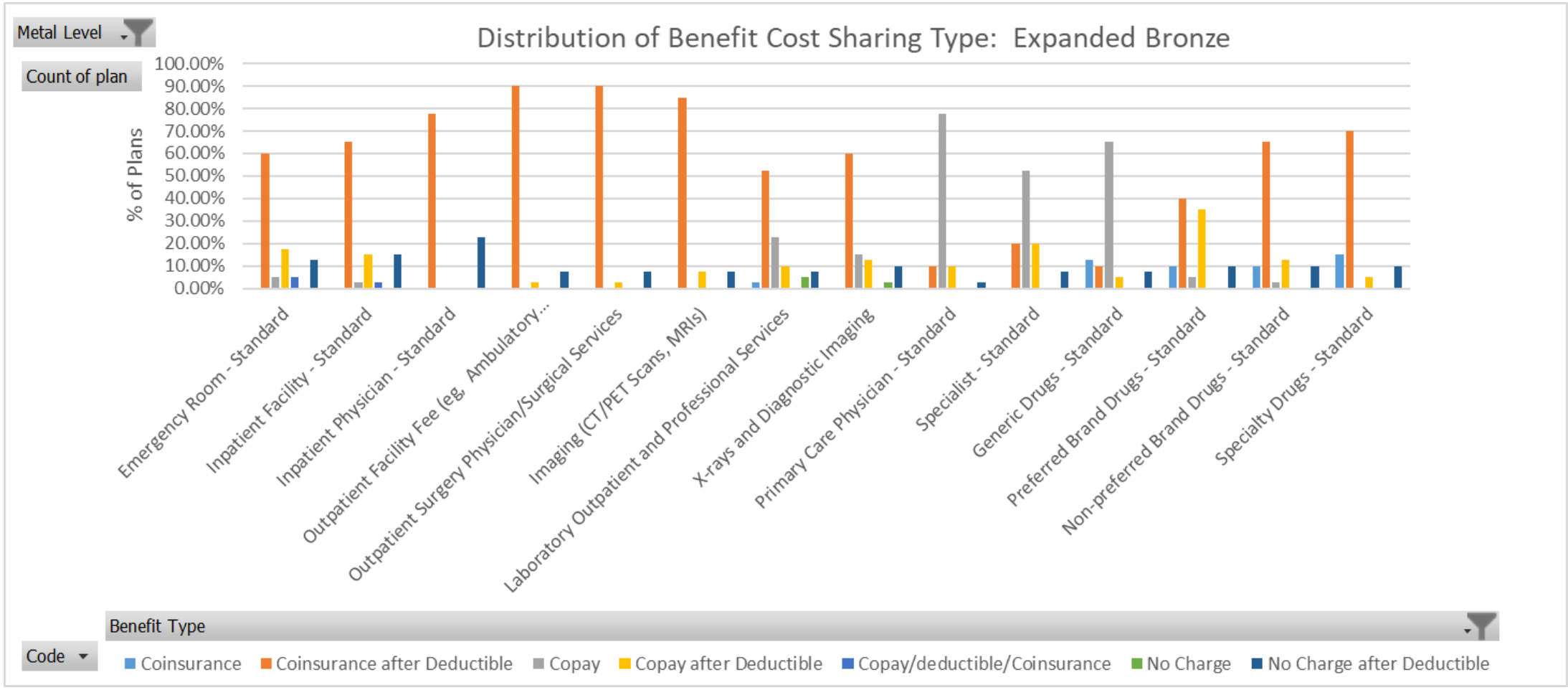
Marketplace Review: 2018 Benefits & Cost Sharing

- Silver



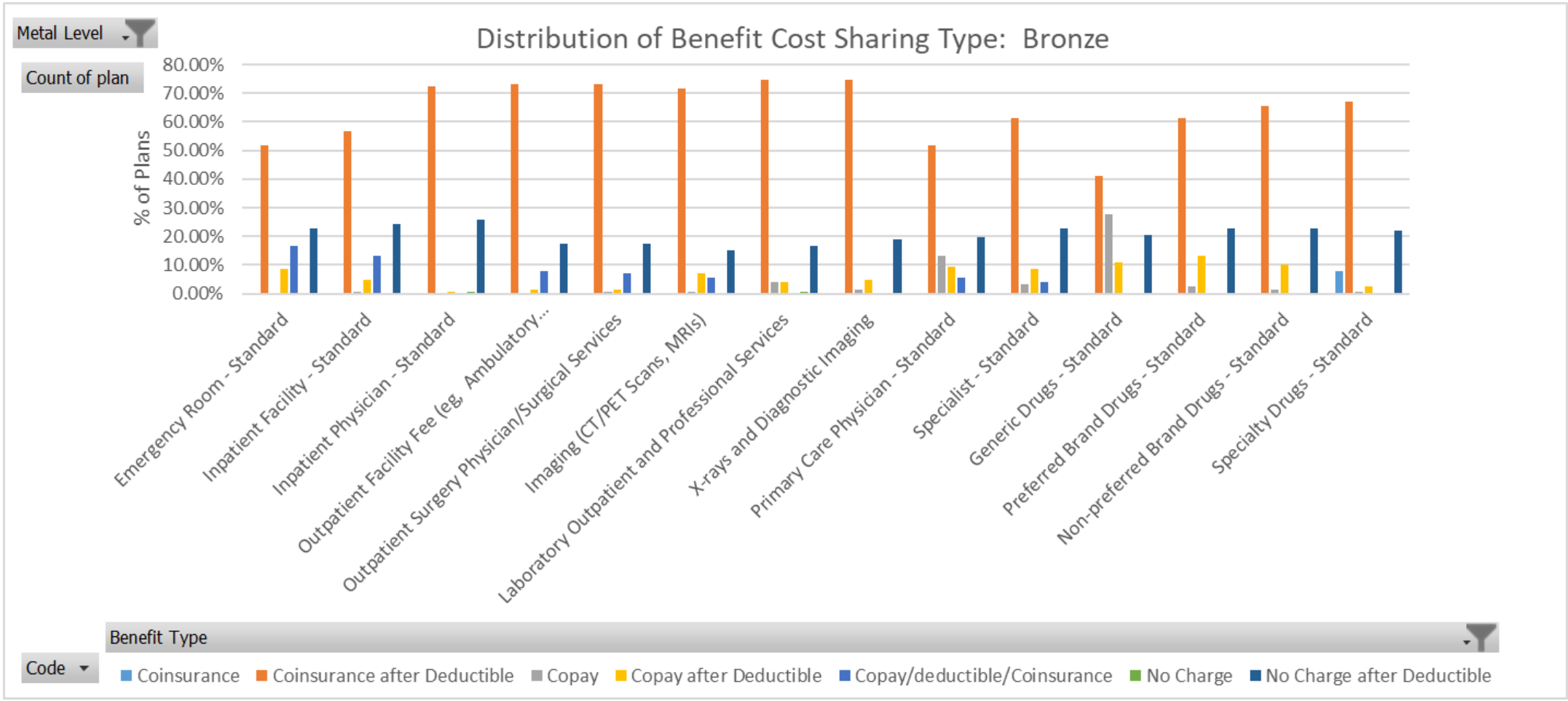
Marketplace Review: 2018 Benefits & Cost Sharing

- Expanded Bronze (up to 65% AV)



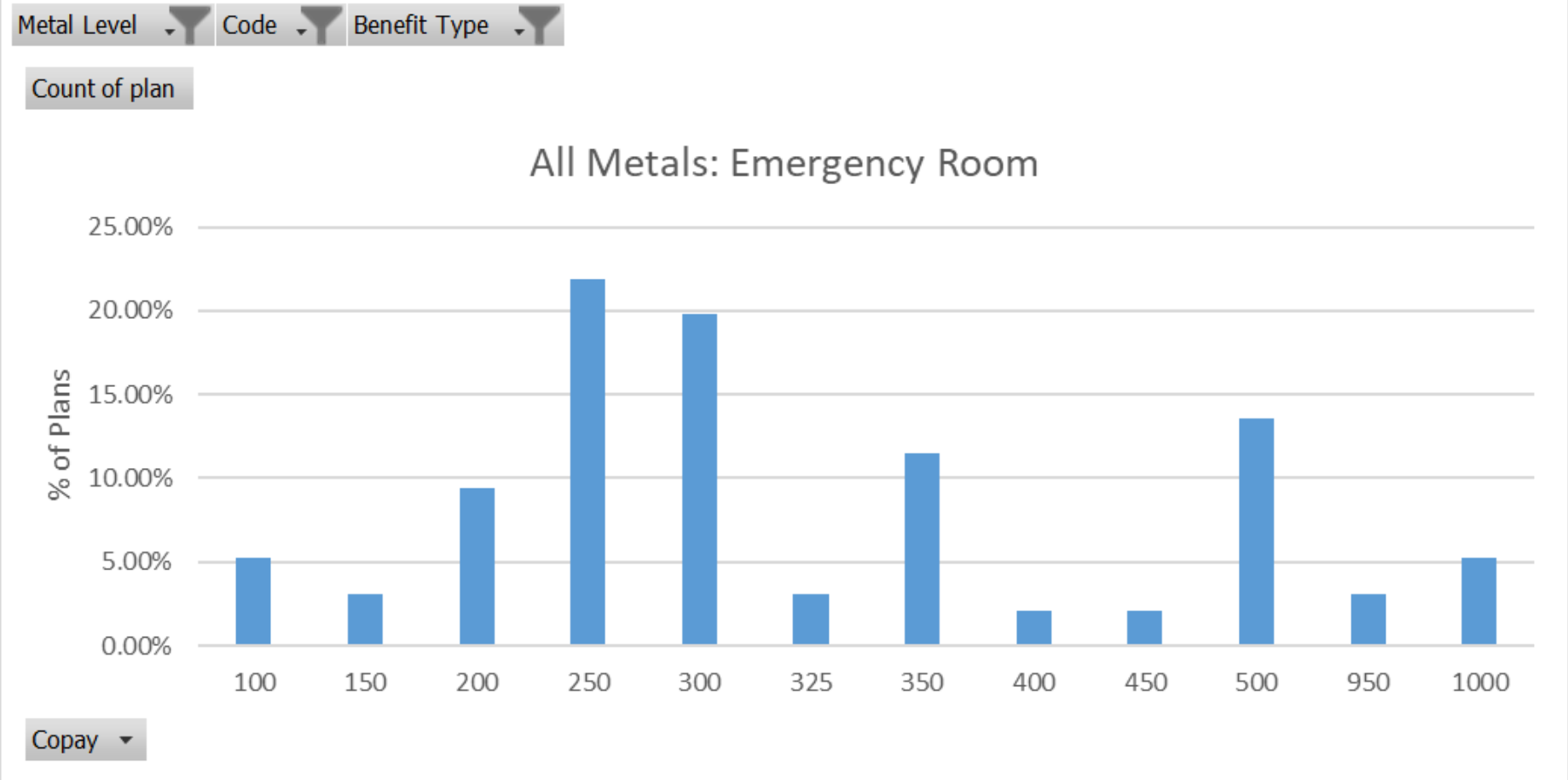
Marketplace Review: 2018 Benefits & Cost Sharing

- Bronze



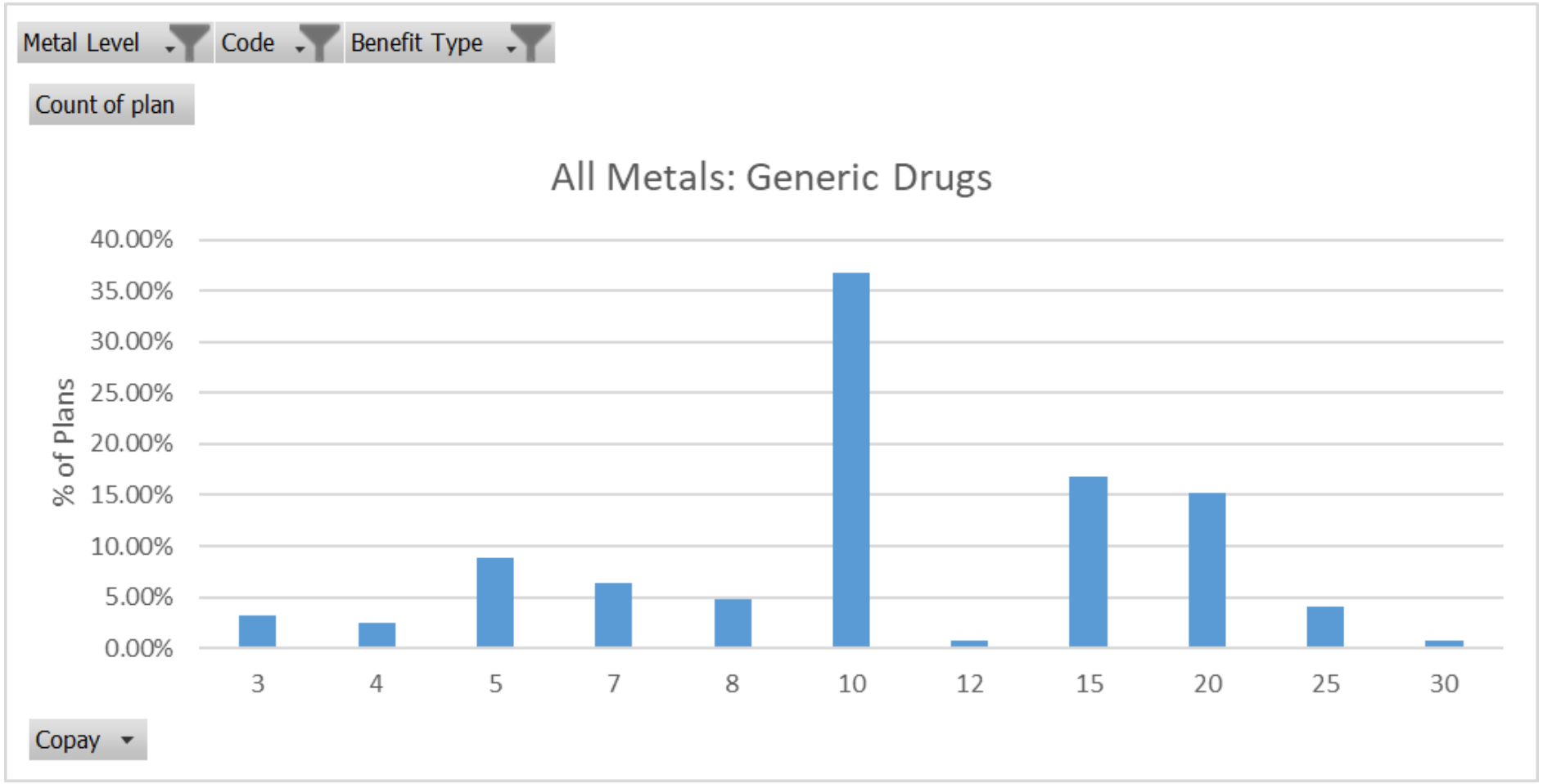
Marketplace Review: 2018 Benefits & Cost Sharing

- Emergency Room copays: w/ Deductible, w/o Deductible, w/ Coinsurance
  - HC 109 Bulletin Max: $200



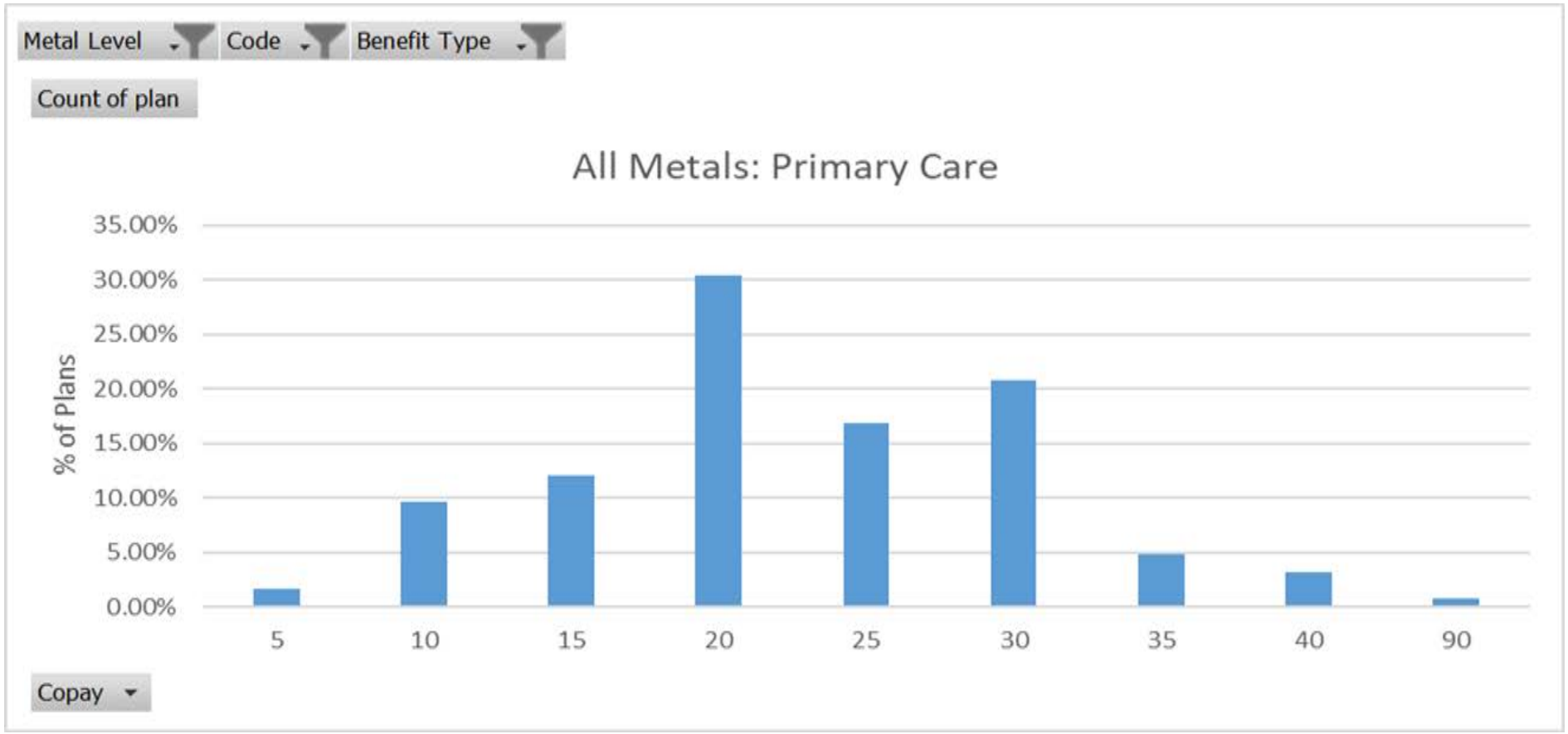
Marketplace Review: 2018 Benefits & Cost Sharing

- Generic Drug copays: w/ Deductible, w/o Deductible, w/ Coinsurance
  - HC 109 Bulletin Max: $5



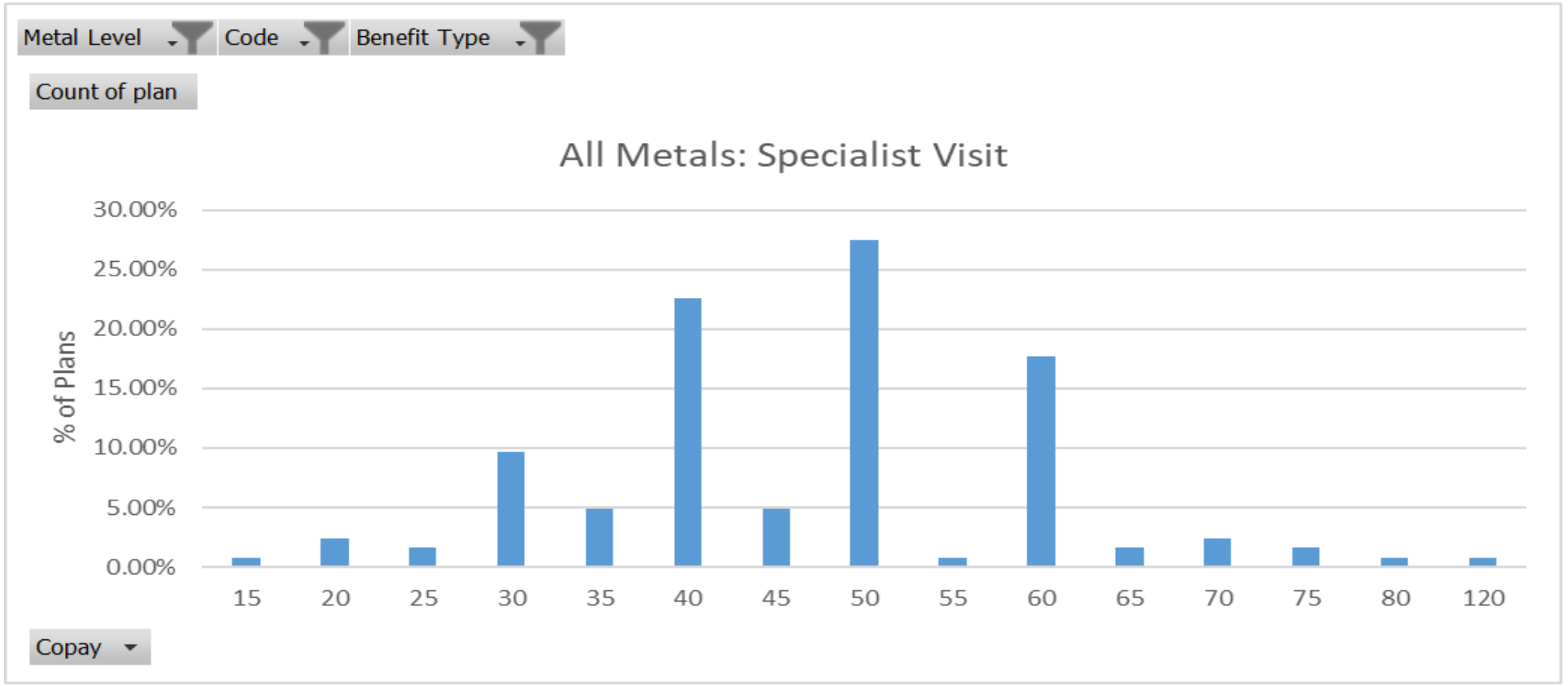
Marketplace Review: 2018 Benefits & Cost Sharing

- Primary Care copays: w/ Deductible, w/o Deductible, w/ Coinsurance
  - HC 109 Bulletin Max: $40



Marketplace Review: 2018 Benefits & Cost Sharing

- Specialist Care copays: w/ Deductible, w/o Deductible, w/ Coinsurance
  - HC 109 Bulletin Max: $50



2019 Plan Design Review

Regulation Changes for 2019

- Proposed annual limitation on cost sharing was increased to $7,900 (from $7,350 in 2018)
  - Note: This limit does not apply to HSA qualified High Deductible Health Plans (HDHPs). That limit is released by the IRS in the spring.
  - CSR Variations proposed annual limitation on cost sharing
    - 100-150% FPL: $2,600/$5,200 (single/family)
    - 150%-200% FPL: $2,600/$5,200 (single/family)
    - 200%-250% FPL: $6,300/$12,600 (single/family)
- Expanded bronze “de minimis” range allows bronze plans with certain designs to have an AV between 58% and 65% (compared to 58% and 62% prior to 2018).
  - Applicable plans include HDHP plans, or plans that cover at least one major service, other than preventive, prior to the deductible.

Changes to the Federal AVC for 2019

- Data underlying the calculator was not updated from prior year
  - Updated annual trend factors to project 2015 claims to 2018 using 3.25% for medical claims and 11.5% for pharmacy claims.
  - Updated annual trend factors to project 2018 claims to 2019 using 5.40% for medical claims and 11.5% for pharmacy claims.

Notes and Caveats

- Federal HDHP minimum deductible and MOOP limits are not yet released for 2019.
  - The 2018 minimum single deductible and MOOP are $1,350 and $6,650, respectively.
  - The proposed plan designs do not make changes to either the HDHP deductible or MOOP.
- The cost sharing shown on the following slides represents costs for in-network services only.
- The deductible and MOOP limits shown are for individuals. The family limits are 2x the individual limit for all plans.
- Preventive care is covered at no cost to the member for all plans.
- Mental Health cost sharing is the same as Primary Care for all plans.

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Maximum Copays

- CID Bulletin HC-109 specified maximum benefit copays.

Service Category	Maximum Copay
Durable Medical Equipment	$25
Home Health Care	$25
Ambulance	$225
Laboratory	$10
Routine Radiology Services	$40
PCP Office Visit	$40
Specialist Office Visit	$50
Urgent Care	$75
Emergency Room	$200
Inpatient Admission	$500/day up to $2,000
Outpatient Surgery/Services	$500
Generic Drug	$5
Brand Drug	$60
Physical Therapy*	$30

- On the following slides, copays at these maximums are shown with an asterisk (*)

* Sec. 38a-511a limits physical therapy copays to $30.

Summary of AV Changes

Individual Market	Gold	Silver	Bronze	Bronze HSA
Permissible AV Range	78.0%-82.0%	68.0%-72.0%	58.0%-65.0% [1]	58.0%-65.0% [1]
2018 AV	81.7%	71.5%	63.9%	61.2%
2019 AV	**82.5%**	**72.8%**	**65.2%**	62.4%

[1] Bronze plan designs are eligible for new expanded "de minimis" range

Individual Market - CSR Plan Variations	73% AV CSR	87% AV CSR	94% AV CSR
Permissible AV Range	72.0%-74.0% [2]	86.0%-88.0%	93.0%-95.0%
2018 AV	73.6%	87.9%	94.9%
2019 AV	**74.8%**	**88.5%**	**95.2%**

[2] 73.0% CSR Silver must be have a differential of 2.0%+ with Standard Silver

2019 - Individual Market Gold Plan, 80% AV

	2018 Individual Market Gold	2019 Individual Market Gold Plan - Option 1
Medical Deductible	$1,250	**$1,300**
Rx Deductible	$50	$50
Coinsurance	30%	30%
Out-of-pocket Maximum	$4,400	**$5,000**
Primary Care	$20	$20
Specialist Care	$40	$40
Urgent Care	$50	$50
Emergency Room	$200	$200
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$65	$65
Non-Advanced Radiology (X-ray, Diagnostic)	$40 * (after ded.)	$40 * (after ded.)
Laboratory Services	$10 * (after ded.)	$10 * (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$20	$20
Chiropractic Care 20 visit calendar maximum	$40	$40
All Other Medical	30%	30%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $25 / $50 / 20% (spec. after ded., $100 max per spec. script)	$5 * / $25 / $50 / 20% (spec. after ded., $100 max per spec. script)
2018 AVC Results	**81.7%**	**N/A**
2019 AVC Results	**82.5%**	**82.0%**
Difference	0.9%	0.3%

Changes from the 2018 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2019 - Individual Market Silver Plan, 70% AV

	2018 Individual Market Silver	2019 Individual Market Silver Plan - Option 1
Medical Deductible	$3,700	**$4,300**
Rx Deductible	$250	$250
Coinsurance	40%	40%
Out-of-pocket Maximum	$7,350	**$7,900**
Primary Care	$40 *	$40 *
Specialist Care	$50 *	$50 *
Urgent Care	$75 *	$75 *
Emergency Room	$200 * (after ded.)	$200 * (after ded.)
Inpatient Hospital	$500 per day (after ded., $2,000 max. per admission) *	$500 per day (after ded., $2,000 max. per admission) *
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75	$75
Non-Advanced Radiology (X-ray, Diagnostic)	$40 * (after ded.)	$40 * (after ded.)
Laboratory Services	$10 * (after ded.)	$10 * (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 *	$30 *
Chiropractic Care 20 visit calendar maximum	$50	$50
All Other Medical	40%	40%
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / $35 / $60 * / 20% (all but generic after ded., $200 max per spec. script)	$5 * / $35 / $60 * / 20% (all but generic after ded., $200 max per spec. script)
2018 AVC Results	**71.5%**	**N/A**
2019 AVC Results	**72.8%**	**71.9%**
Difference	1.2%	0.4%

Changes from the 2018 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2019 - Individual Market Bronze Non-HSA Plan, 60% AV

	2018 Individual Market Bronze Non-HSA	2019 Individual Market Bronze Non-HSA Plan - Option 1
Combined Medical & Rx Deductible	$6,000	$6,000
Coinsurance	40%	40%
Out-of-pocket Maximum	$7,350	**$7,900**
Primary Care	$40 *	$40 *
Specialist Care	$50 * (after ded.)	$50 * (after ded.)
Urgent Care	$75 *	$75 *
Emergency Room	$200 * (after ded.)	$200 * (after ded.)
Inpatient Hospital	$500 per day (after ded., $1,000 max. per admission)	$500 per day (after ded., $1,000 max. per admission)
Outpatient Hospital	$500 * (after ded.)	$500 * (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	$75 (after ded.)	$75 (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	$40 * (after ded.)	$40 * (after ded.)
Laboratory Services	$10 * (after ded.)	$10 * (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	$30 * (after ded.)	$30 * (after ded.)
Chiropractic Care 20 visit calendar maximum	$50 (after ded.)	$50 (after ded.)
All Other Medical	40% (after ded.)	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / 50% / 50% / 50% (all but generic after ded., $500 max per spec. script)	$5 * / 50% / 50% / 50% (all but generic after ded., $500 max per spec. script)
2018 AVC Results	**63.9%**	**N/A**
2019 AVC Results	**65.2%**	**64.6%**
Difference	1.3%	0.7%

Changes from the 2018 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

2019 - Individual Market Bronze HSA Plan, 60% AV

	2018 Individual Market Bronze HSA
Combined Medical & Rx Deductible	$5,685
Coinsurance	10%
Out-of-pocket Maximum	$6,550
Primary Care	10% (after ded.)
Specialist Care	10% (after ded.)
Urgent Care	10% (after ded.)
Emergency Room	10% (after ded.)
Inpatient Hospital	10% (after ded.)
Outpatient Hospital	10% (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	10% (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	10% (after ded.)
Laboratory Services	10% (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	10% (after ded.)
Chiropractic Care 20 visit calendar maximum	10% (after ded.)
All Other Medical	10% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	10% / 15% / 25% / 30% (all after ded., $500 max per spec. script)
2018 AVC Results	**61.2%**
2019 AVC Results	**62.4%**
Difference	1.2%

Changes from the 2018 plan design are shown in red font and boxes.
*Cost sharing at maximum copay allowable as specified by Insurance Department Bulletin HC-109

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- **Refer to Separate Handout For Additional Plan Designs for Consideration**

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➢Follow-Ups from Previous Meetings

Plan Mix - Medical

Current Guidelines: Number of Plans Permitted per Issuer				
	Individual Market		Small Group Market*	
	Standardized	Non-Standard	Standardized	Non-Standard
Platinum	1 (Optional)	2	0	4 (Optional)
Gold	1	3	0	Min 1 – Max 6
Silver	1	3	0	Min 2 – Max 6
Bronze	2	3	0	Min 2 – Max 4
Catastrophic	N/A	1	N/A	N/A
TOTAL	4 Required / 1 Optional	12 Optional	0 Required	5 Required / 15 Optional
Maximum	17		20	

2018 Submitted Plans

20 in Individual market (two issuers):

- **8 standardized plans (no Platinum)**
- **Non-standard plans: 1 Gold, 5 Silver, 4 Bronze and 2 Catastrophic**

14 in Small Group market (two issuers):

- **Non-standard plans:**
- **1 Platinum, 3 Gold, 5 Silver, 5 Bronze**

*Effective for the 2018 plan year, AHCT removed the requirement for Issuers to submit standardized plans for SHOP;
The minimum count of plans are required to include out-of-network coverage and include pediatric dental EHBs

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Should AHCT eliminate the option for carriers to submit non-standard Silver plans in the Individual Market?

Reasons not to eliminate…	Reasons to eliminate…
• Provides consumers with additional plan choices • May result in increased competition, and potentially, lower rates • If non-standard plans are not also available, could result in fewer innovative plan design offerings through the exchange • High risk probability of market disruption, member confusion and reduction in auto-renewal efforts if non-standard plans are eliminated	• May reduce administrative and operational costs for both AHCT and carriers • May result in improved understanding of plan benefits (i.e., health literacy) with focus on fewer plans • Premium subsidy may increase with elimination of a non-standard plan that would otherwise be designated as the second lowest cost Silver plan (SLCSP) when priced slightly above the standardized Silver plan

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- **Discussion on vote to recommend eliminating the option for issuers to submit non-standard Silver plans in the Individual Market**

Should AHCT eliminate the requirement that the lowest cost Silver plan in the Individual Market be the AHCT standardized plan?

Reasons not to eliminate the requirement…	Reasons to eliminate…
• Results in 'affordability' (as defined by ACA) of the AHCT standardized Silver plan • Could result in the calculation of PTCs based on non-standard Silver plans (when available) that are less costly due to features such as: different product type, narrow network composition, streamlined formulary, most services subject to annual plan deductible, HSA-compatible plans, exclusion of pediatric dental coverage (if an ACA compliant stand-alone dental plan is available) • Could result in lower out-of-pocket plan costs for consumers • Could result in significant movement from current plan selection to an alternative plan at renewal for many enrollees in an attempt to minimize premium impact, as the amount of premium tax credit (PTC) might be based on a lower cost plan	• May result in overall reduction in premium for Silver plans as a result of increased competition

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- **Discussion on vote to recommend eliminating the requirement that the lowest cost Silver plan in the Individual Market be the AHCT standardized Silver plan**

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- **Additional Certification Requirements**

Tobacco Use Surcharge: Regulations & Guidance

45 C.F.R §147.102	• Tobacco surcharge permitted (cannot vary by more than 1.5:1 vs premium rate for non-smokers) • May only be applied for those who may legally use tobacco under federal and state law • Tobacco use is defined as consumption of tobacco on average four or more times per week (within no longer than the past 6 months) & includes all tobacco products, except religious/ceremonial use • Tobacco use must also be defined in terms of when a tobacco product was last used
26 C.F.R §1.36B-3(e)	• The premium tax credit amount may not include any adjustments for tobacco use
Connecticut General Statute §38a-567	• Tobacco use is not an allowed case characteristic & is therefore not applicable in the small employer market in Connecticut
AHCT Certification Guidance	• Per March 7, 2017 vote by Board of Directors, effective for the 2018 plan year, inclusion of a tobacco surcharge in the premium rates for QHPs in the Individual Market is permitted

C.F.R. = Code of Federal Regulations

Tobacco Use Surcharge System & Operational Considerations

Topic	High Level Business Impacts	Status
Plan Management Portal	• Modify database to accept 2 sets of rates (tobacco/non-tobacco) for applicable age bands/rating areas for each submitted plan	TBD
Anonymous Browsing & Enrollment	• Add questions regarding tobacco usage/last time tobacco was used for all potential enrollees legally allowed to use tobacco (primary & dependents) to determine whether surcharge should apply • Modify system to select appropriate tobacco/non-tobacco rate for each enrollee to provide accurate estimate of plan costs • Adjust premium calculation to add tobacco surcharge after the premium tax credit calculation is performed • Include 'tool tip' outlining whether tobacco use would apply to a specific individual (e.g., tobacco type, frequency & duration of use)	TBD
Database Storage	• Tobacco use indicator to be stored within AHCT database, including time periods for which it applies	TBD
Electronic Data Interchange	• Transmit tobacco use indicator and/or date tobacco last used to carrier	TBD
Affordability Exemption	• Must take into account premium rates including tobacco surcharge	TBD
Auto-Enrollment	• Tobacco use status for existing enrollees is unknown, therefore further discussions regarding process to include for those eligible for auto-enrollment is needed	TBD

Broker Compensation

AHCT Board of Directors Votes	**1/26/17: To require any health carrier offering a health insurance plan through the Exchange to pay a commission to an insurance producer or broker who assists an individual or small employer in enrolling in a health insurance plan through the Exchange** **3/7/17: To require that the amount of commission a carrier pays to a producer or broker who assists an individual or small employer enrolling in a health insurance plan through the Exchange be similar to the amount of commission the carrier pays to producers or brokers who assist individuals or small employers in enrolling in health plans outside of the Exchange**
AHCT QHP Solicitation: Plan Year 2018*	**Commissions on the exchange must be "similar" to a carrier's commission off exchange. Commissions will be deemed similar if the following conditions are met:** • **A commission is payable on the exchange for a plan if the carrier pays a commission for a comparable plan and service functions off exchange** • **A comparable plan is one at the same metal tier or a subset of that tier if commissions are limited to a specific type of offering such as a plan sold in conjunction with a tax qualified health spending account** • **If a carrier does not offer plans off exchange, a commission shall be payable based upon a comparable plan of an affiliate. In the case there is not affiliate, a commission shall be payable based upon a comparable plan of other carriers participating on the exchange**

**Similar text used for AHCT Stand-alone Dental Plan (SADP) Solicitation for Plan Year 2018*

Certification Requirements Policy

- AHCT Policy titled "Establishing Requirements for Certification, Recertification and Decertification of Qualified Health Plans"* was adopted by the AHCT Board of Directors on 11/29/2012
  - Excerpts of the document:
    - The Exchange shall establish requirements for certification, recertification and decertification of qualified health plans ("QHPs") in accordance with the requirements of the Affordable Care Act ("ACA"), 45 CFR Parts 155 and 156 and CGS §§ 38a-1080 et seq. (the "Exchange Act").
    - Members of the Exchange staff (the "Staff"), in consultation with the Exchange's Health Plan Benefits and Qualifications Advisory Committee (the "Committee"), are charged with evaluating options and making recommendations to the Board of the Exchange regarding requirements for the certification, recertification and decertification of QHPs. The Staff and the Committee will be assisted by a subject matter expert designated by the Connecticut Insurance Department.
  - References specific items that the Committee would review for inclusion in certification requirements
  - Outlines that the Committee will take into account recommendations of the Consumer Experience and Outreach Advisory Committee as well as federal and state regulations and guidance
  - AHCT will be revising the document to make a technical correction to contact information included

*Located at the following URL: http://agency.accesshealthct.com/wp-content/uploads/2016/10/Policies-and-Procedures-Certification-of-Qualified-Health-Plans-00038757-4.pdf

Next Steps

- Consider need for additional HPBQ AC meetings and survey on potential dates
- Next Meeting scheduled for January 10th
  - Agenda topics outlined on slide 6
  - Includes continuation of discussion regarding 2019 standardized Plans for Individual Market (Gold, Silver, Bronze)
  - Expect to include review of the ‘Plan Mix’ for the Small Business Health Options Program (SHOP)

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➢Adjournment

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➢Appendix

2017 AHCT Plan Enrollment: Standardized/Non-Standard QHPs

Enrollment data of Individual AHCT plans as of 9/28/2017

Metal Level	Enrollment	Percent
Catastrophic	1,550	1.61%
Bronze	24,735	25.76%
Silver	60,414	62.93%
Gold	9,310	9.70%
TOTAL	96,009	100.00%

Metal Level	Standardized Plans	Non-Standard Plans	Total	Percent in Standardized Plans
Catastrophic	0	1,550	1,550	0.00%
Bronze*	21,958	2,777	24,735	88.77%
Silver	51,339	9,075	60,414	84.98%
Gold	7,278	2,032	9,310	78.17%
TOTAL	80,575	15,434	96,009	83.92%

*Bronze Plans	Standardized Plans	Non-Standard Plans	Total	Percent in Standardized Plans
Non-HSA Bronze	7,783	803	8,586	90.65%
HSA Compatible	14,175	1,974	16,149	87.78%
Total	21,958	2,777	24,735	88.77%

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2017 AHCT Plan Enrollment: Standardized/Non-Standard QHPs

	GOLD		SILVER		BRONZE (HSA compatible)		BRONZE (not HSA compatible)		CATASTROPHIC	
County	Non-Std	Standard	Non-Std	Standard	Non-Std	Standard	Non-Std	Standard	Non-Std	Grand Total
Fairfield	450	2,435	2,667	15,879	454	4,914	178	2,441	395	29,813
Hartford	275	1,680	1,759	12,069	325	3,427	125	1,467	432	21,559
Litchfield	209	522	705	3,489	192	924	65	548	105	6,759
Middlesex	59	403	422	2,504	80	805	25	385	90	4,773
New Haven	583	1,414	1,797	11,291	468	2,620	224	1,720	334	20,451
New London	251	402	888	3,279	268	659	118	658	106	6,629
Tolland	120	250	446	1,544	90	535	33	341	65	3,424
Windham	85	172	391	1,284	97	291	35	223	23	2,601
Total	2,032	7,278	9,075	51,339	1,974	14,175	803	7,783	1,550	96,009
	9,310		60,414		16,149		8,856		1,550	96,009

Enrollment data of Individual AHCT plans as of 9/28/2017

Tobacco Use: Facts & Figures

- Per the Centers for Disease Control and Prevention website*
  - 36.5% of adults with any mental illness reported current use** of tobacco in 2013 compared to 25.3% of adults with no mental illness
  - People living below the poverty level and people having lower levels of educational attainment have higher rates of cigarette smoking than the general population
  - Among people having only a GED certificate, smoking prevalence is more than 40%
  - 29.8% of African American adults reported current use** of tobacco in 2013
  - 20.9% of Hispanic/Latino adults reported current use** of tobacco in 2013
- A Kaiser Health News article from May 2016 indicated that smokers may be avoiding the surcharge in states that include it by not reporting tobacco use status appropriately, citing the following:
  - Idaho: per federal survey, 17% of adults smoke regularly, but < 3% who bought coverage in 2016 on the state's insurance exchange paid the surcharge
  - Kentucky: over 25% of adults smoke regularly, but 11% paid the tobacco surcharge
  - Minnesota: 18% of adults smoke, but < 5% paid the tobacco surcharge

* https://www.cdc.gov/tobacco/disparities/index.htm

*** "Current Use" per CDC website was defined as self-reported consumption of cigarettes, cigars, smokeless tobacco, and pipe tobacco in the past year and past month (at the time of survey)*