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Access Health CT
Board of Directors Meeting
Public Comment
March 20, 2018

RE: **Tobacco Surcharges on Health Insurance Premiums and State Flexibility**

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to provide comments on the proposed inclusion of tobacco surcharges in 2019 plans offered through Access Health CT and to discuss the serious impact tobacco use has on Connecticut's health and economy. ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society that supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. In 2017 it is estimated that approximately 21,240 Connecticut residents will be diagnosed with cancer while 6,590 will die from the disease[i].

ACS CAN places a high priority on evidenced-based tobacco control policies that prevent cancer and other diseases and save lives. Charging tobacco users higher health insurance premiums is not proven to reduce smoking, and in fact, may result in reduced access to health care for those who need it most.

Charging smokers more for health insurance is an unproven way to address tobacco use when we have decades of success in several thoroughly tested, evidenced based ways to improve public health through raising the price of tobacco products, creating smoke-free venues and implementing tobacco use prevention and cessation programs.

Higher health insurance premiums based on tobacco use will create barriers for individuals who need coverage the most, including low income tobacco users with less quality health care options but more likely to have serious health problems from smoking. Because they can't afford the potentially thousands of dollars in extra premiums, they will likely remain uninsured and lose access to treatment to stop smoking or help them with the variety of smoking-related health conditions.

Age-dependent tobacco surcharges of up to 50% are allowed under the Affordable Care Act. To learn how many insurance plans were implementing the optional surcharge, researchers measured tobacco surcharges around the country in 2015, and found wide variation. A 2015 American Cancer Society study in the *American Journal of Public Health*, found tobacco users would pay more for a health insurance plan from the Affordable Care Act exchanges than non-

tobacco users in nearly every county of the 37 states that used healthcare.gov to sell their plans in 2015[ii]. In some instances, tobacco users would pay up to 46% more. Surcharges for the least expensive "bronze" health insurance exchange plans varied greatly in magnitude and manner across age as well as within and between states.

The study shows these premiums vary almost randomly across the country and strike some people very hard, while they aren't being imposed at all on others. These surcharges are likely to harm older tobacco users, the very ones who are most likely to become sick due to their smoking. Older smokers are then faced with a choice to either lie about their tobacco usage to their insurance company and possibly their physician, or they can try to pay the surcharge and bear the financial burden of heavy monthly premiums that do not provide them with any extra benefit. A final option would be to not purchase coverage at all.

Applying the tobacco surcharge goes directly against the purpose of the ACA – to provide access to quality, afford able health insurance to more people, especially those with serious health problems.

Specific vulnerable populations will be hit hardest by the tobacco surcharge by being priced out of affordable health insurance. Tobacco users, particularly smokers, are more likely to be in a racial minority, low income and less educated. They are more likely to have and to die from tobacco- related diseases like cancer, lung and heart disease than higher income or non-racial minority populations.

Connecticut should not apply the tobacco rating, or at least include policies that minimize negative impacts on tobacco users.

- Connecticut should use the flexibility offered in the ACA to **NOT** apply the tobacco rating.
- If the tobacco rating is applied, it should be lower than 1:5:1 and as small as possible.
- If the tobacco rating is applied, it should apply only to beneficiaries age 18 and older.
- Connecticut should include comprehensive cessation benefits at low or no cost in all private and public plans and in state regulations for insurance plans. Under the ACA, cessation services must be offered in new plans in the small group and individual markets and provided to pregnant women in Medicaid. However, research shows that insurers and states are currently doing a poor job of implementing and communicating these benefits. Connecticut must close these gaps and eliminate discrepancies in benefits.

Connecticut will see greater public health and economic benefits by raising tobacco excise taxes, implementing strong smoke-free laws, and funding prevention and cessation programs than by raising insurance rates on tobacco users.

The Toll of Tobacco Use in Connecticut

Despite significant progress since the first Surgeon General's report, issued over 50 years ago, tobacco related diseases are the single most preventable cause of death in our society, yet according to DPH statistics, ***tobacco use continues to kill more people in Connecticut each year than alcohol, AIDS, car crashes, illegal drugs, accidents, murders and suicides combined***[iii]***.***

Tragically, 4,900 adults will die in Connecticut from smoking this year—13 per day. Meanwhile, 1300 kids will become new daily smokers—over 3 per day, every day[iv]. Statistically speaking, therefore, two or three people in Connecticut will have died from causes related to tobacco use during the course of this hearing today. Sadly, someone in Connecticut will have tried tobacco for the first time during the course of this hearing as well—with about a 95 percent chance that person is under 18. In fact, 56,000 kids alive today in Connecticut will die prematurely from tobacco use[v].

In FY '19, Connecticut is projected to receive $504 million in combined revenue from tobacco taxes and from the Master Settlement Agreement, which amounts to $57,400 every hour of every day[vi]. However, Connecticut incurs $2.03 billion in annual health care costs related to tobacco use, or $231,000 every hour of every day[vii]. ***The cost of tobacco is $173,600 more per hour than we receive in revenue. Every hour, every day.***

Master Settlement

In 1998, 46 states entered into an agreement with the "Big 4" tobacco companies to settle lawsuits aimed to recover state healthcare costs related to tobacco use. This Master Settlement requires tobacco companies to make annual payments in perpetuity to the states. However, while the intent was to reimburse states for healthcare costs due to tobacco use, the agreement did not require payments be dedicated to tobacco prevention and cessation.

In 1999, the Legislature established a Tobacco and Health Trust Fund (THTF) to among other things "create a continuing significant source of funds to … support and encourage development of programs to reduce tobacco abuse through prevention, education and cessation programs." The trust fund is a separate non-lapsing fund that accepts transfers from the Tobacco Settlement Fund however the THTF has been subject to significant redirection of funds over the years.

Tobacco Taxes

Connecticut established its first tax on tobacco products in 1935. The bi-partisan budget passed in October 2017 increased, as of January 1, 2018, the state tax on cigarettes by .45 cents to $4.35, tying New York for the highest state tax in the country. The tax on snuff tobacco products was also increased to $3 per ounce. Taxes on all other tobacco products are 50% of the wholesale price while the tax on cigars is capped at .50 cents per cigar—both unchanged since 2011.

Connecticut is first in taxes but last in tobacco control and prevention funding.

Tobacco Control and Prevention Funding

Over the years just over 1% of the cumulative total deposited into the Tobacco and Health Trust fund has been spent in support of smoking cessation services. In 2013 the state spent $6 million on Tobacco control, for 2014 and 2015 that number was cut in half. However, for FY '16, FY '17, FY '18 and now FY '19, that number is zero. *Our children are worth more than zero*.

It gets worse. Since its inception in 2000, the THTF has been raided or had funds redirected 78 times. Of the total deposits into the THTF since 2000, only $29.2 million has been spent on tobacco control while just over $277 million has been redirected to non –tobacco related programs, including $183 million redirected directly into the General Fund[viii].

The CDC recommends $32 million be spent on tobacco control programs in Connecticut *per year*[ix]*.* To put it starkly, we have dedicated a cumulative total of $29.2 million for tobacco control during those 18 years-- *$2.8 million less than the CDC recommends we spend annually*.

Fully Funding Evidence-Based Tobacco Prevention and Cessation Programs

The 2014 Surgeon General's report found, "States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarettes sales than the nation as a whole, and the prevalence of smoking among adults and youth has declined faster, as spending for tobacco control programs has increased.[x]" The report concluded that long-term investment is critical: "Experience also shows that the longer the states invest in comprehensive tobacco control programs, the greater and faster the impact."

States that have funded tobacco control have indeed seen results:

- In Washington State, the state's tobacco control program cut adult smoking by a third and youth smoking in half and prevented an estimated 13,000 premature deaths and nearly 36,000 hospitalizations, saving about $1.5 billion in health care costs. Additionally, the state saw a 5-1 saving with their program between 2000-2009[xi]
- Florida, which has a constitutional amendment that provides $66 million per year, has seen their adult smoking rate plummet from 21.1% in 2007 to 16.8% in 2014 and their youth smoking rate drop to 6.9% in 2015 from a high of 10.5% in 2006[xii].
- In California, lung cancer rates declined by a third between 1988 and 2011 reducing lung and bronchus cancer rates four times faster than the rest of the United States. In addition, California saw a $55 to $1 return on investment between 1989 and 2008[xiii]
- Alaska, one of only two states to fully fund according to the CDC recommendations, has cut its high school smoking rate by 70% since 1995[xiv].
- Maine reduced its youth smoking rates by two thirds between 1997-2013[xv].
- From 2009 to 2015, smoking among North Dakota's high school students fell by 48 percent, from 22.4 percent to 11.7 percent. All of these states have made significant, long-term investments in tobacco control[xvi].

Many tobacco users fail quit attempts because, in part, of a lack of access to successful cessation programs. Funding tobacco use prevention and cessation programs that alleviate this

burden on our citizens and economy are not only consistent with our shared goal of insuring access to care to those in need, it is also the only fiscally responsible approach we can take.

Significant and Regular Increases in Tobacco Taxes on All Tobacco Products
Regular tax increases of $1.00 or more per pack of cigarettes and equivalent increases in the tax on other tobacco products (OTPs) are a win-win for states: a health win that reduces tobacco use and saves lives and a fiscal win as it raises much-needed revenue.

- Save Lives: Regular and significant tobacco tax increases are one of the most effective ways to reduce tobacco use and, therefore, suffering and death from tobacco-related diseases like cancer. Studies have shown that, nationwide, every real 10 percent increase in the price of cigarettes reduces youth smoking by about 6.5 percent and overall consumption by about 4 percent.[xvii] [xviii]

- Save Money: Significant increases to cigarette and tobacco taxes result in substantial revenue increases for states as well as health care cost savings. Every state that has significantly increased its cigarette tax in recent years has seen increases in revenue.

When different types of tobacco products are taxed at different rates, lower-taxed products are cheaper than they would be if all tobacco products were taxed at an equivalent rate. By increasing the tax on all tobacco products to an equivalent rate, states can help reduce tax evasion, generate more new revenue, prevent initiation of these products, and ensure that more tobacco users quit instead of switching to a cheaper product.

Comprehensive Smoke-free Laws
According to the U.S. Surgeon General, there is no safe level of exposure to secondhand smoke, which contains approximately 70 known or possible carcinogens.[xix] [xx] Each year in the United States, secondhand smoke causes nearly 42,000 deaths among nonsmokers, including up to 7,300 lung cancer deaths.[xxi] [xxii] Throughout the country, elected officials at the state and local levels are recognizing the health and economic benefits of comprehensive smoke-free laws. The only way to fully eliminate exposure to secondhand smoke is to prohibit smoking in all public places, making them 100 percent smoke-free.

- Reduce Exposure to Secondhand Smoke: Smoke-free laws reduce exposure to secondhand smoke, encourage and increase quitting among current smokers, and reduce health care, cleaning, and lost productivity costs.[xxiii] [xxiv]

- Improve Health: Smoke-free laws have been proven to improve the health of workers in those establishments, as well as the general public. Comprehensive smoke-free laws have been shown to reduce hospital admissions and deaths from respiratory disease, coronary events and other heart disease, and cerebrovascular accidents in hospitality workers.[xxv] [xxvi]

- Good for Business: Smoke-free laws protect health without impacting business. The U.S. Surgeon General's Report concluded, "Evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry."[xxvii]

The American Cancer Society Cancer Action Network stands ready and willing to work with members of Access Health CT as well as the Legislature and the Administration to effectively establish a sound strategy which adequately addresses tobacco use, including the lopsided discrepancy between incoming tobacco related revenue and outgoing expenditures. Continuing on the path we are on now will ultimately do nothing to address an entirely preventable problem. This in turn will only escalate the current fiscal pressures and result in a greater number of lives being affected by cancer at a greater cost to the state.

Thank you for your consideration of our comments.

Bryte Johnson
Connecticut Government Relations Director
American Cancer Society Cancer Action Network

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Tobacco Surcharges on 2015 Health Insurance Plans Sold in Federally Facilitated Marketplaces: Variations by Age and Geography and I....

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Tobacco Surcharges on 2015 Health Insurance Plans Sold in Federally Facilitated Marketplaces: Variations by Age and Geography and Implications for Health Equity

In 2014, few health insurance plans sold in the Affordable Care Act's Federally Facilitated Marketplaces had age-dependent tobacco surcharges, possibly because of a system glitch. The 2015 tobacco surcharges show wide variation, with more plans implementing tobacco surcharges that increase with age. This underscores concerns that older tobacco users will find postsubsidy health insurance premiums difficult to afford. Future monitoring of enrollment will determine whether tobacco surcharges cause adverse selection by dissuading tobacco users, particularly older users, from buying health insurance. (*Am J Public Health.* 2015;105: S696–S698. doi:10.2105/AJPH.2015.302694)

Alex C. Liber, MSPH, Jeffrey M. Drope, PhD, Ilana Graetz, PhD, Teresa M. Waters, PhD, and Cameron M. Kaplan, PhD

TOBACCO USE IS THE LEADING cause of preventable death and disability in the United States. Policy responses to this public health concern have taken many forms, some with unintended consequences for health equity. For example, some argue that tobacco surcharges on health insurance premiums provide incentives to stop tobacco use,[1] but this policy may reduce access to health care for already vulnerable populations if it makes insurance unaffordable.

Health insurance exchanges set up by the Affordable Care Act (ACA; Pub L No. 111–148) allow Americans with incomes between 138% and 400% of the federal poverty line to purchase publicly subsidized, community-rated private health insurance plans in a competitive market. In 2014, more than 7 million people purchased plans from health insurance exchanges, and federal government agencies project that between 9 and 13 million people will sign up in 2015.[2] The price for health insurance exchange plans is determined by only 4 factors; (1) family size, (2) geography (usually a county or state), (3) age (a 64-year-old individual's premium may not exceed 3 times that of a 21-year-old individual), and (4) tobacco use (tobacco users may be charged up to 50% more than nonusers).

Health advocates are concerned that the tobacco rating factor (also known as a tobacco surcharge) makes health insurance unaffordable to tobacco users. This may be exacerbated for those eligible for subsidies because ACA-provided plan subsidies do not cover the tobacco surcharge portion of plan premiums. The higher net premium facing tobacco users may lead them to forgo purchasing health insurance altogether[3] or to misrepresent their true tobacco use status when purchasing insurance on health insurance exchanges. In addition, because the mandate to purchase health insurance exempts individuals without access to affordable coverage (defined as the least expensive premium for an adequate health insurance plan costing less than 8% of gross income), many tobacco users will not be penalized for failing to purchase insurance.[4]

Kaplan et al.[4] found that the tobacco surcharges levied in health insurance exchanges during the 2014 coverage year varied greatly across the largest metropolitan areas in each state for 45-year-old tobacco users. We expand on this prior work by comparing 2015 premium data for all markets in available states participating in the Federally Facilitated Marketplaces. Furthermore, because of a documented glitch in the health insurance exchange pricing structure, few states employed age-dependent tobacco surcharges in 2014.[4] Specifically, the system that processed rates for federally run exchanges would not allow premiums for 64-year-old tobacco users to be more than 3 times those offered to 21-year-old tobacco users, although charging up to 4.5 times more to those persons than to 21-year-old persons was expressly allowed by law as a result of the multiplicative effects of age variation and the tobacco surcharge.[5] This glitch was fixed for 2015, and we offer an early look at the new tobacco surcharges and how those structures may affect health insurance purchasing decisions.

METHODS

We used the Health Insurance Marketplace public use files published by the Centers for Medicare and Medicaid Services in our analysis.[6] We examined the unsubsidized monthly premiums that individuals would pay for health insurance plans offered in the individual marketplaces for the 37 states that were served by Federally Facilitated Marketplaces that either partnered with or exclusively relied on the federal government to operate their 2015 health insurance exchanges. Our main outcome, the minimum effective tobacco use surcharge, was calculated at the county level for each age between 21 and 65 years as the difference between the least expensive bronze plan available for tobacco users and the least expensive bronze plan for nonusers as follows: minimum effective tobacco use surcharge = (minimum bronze premium for a tobacco user) – (minimum

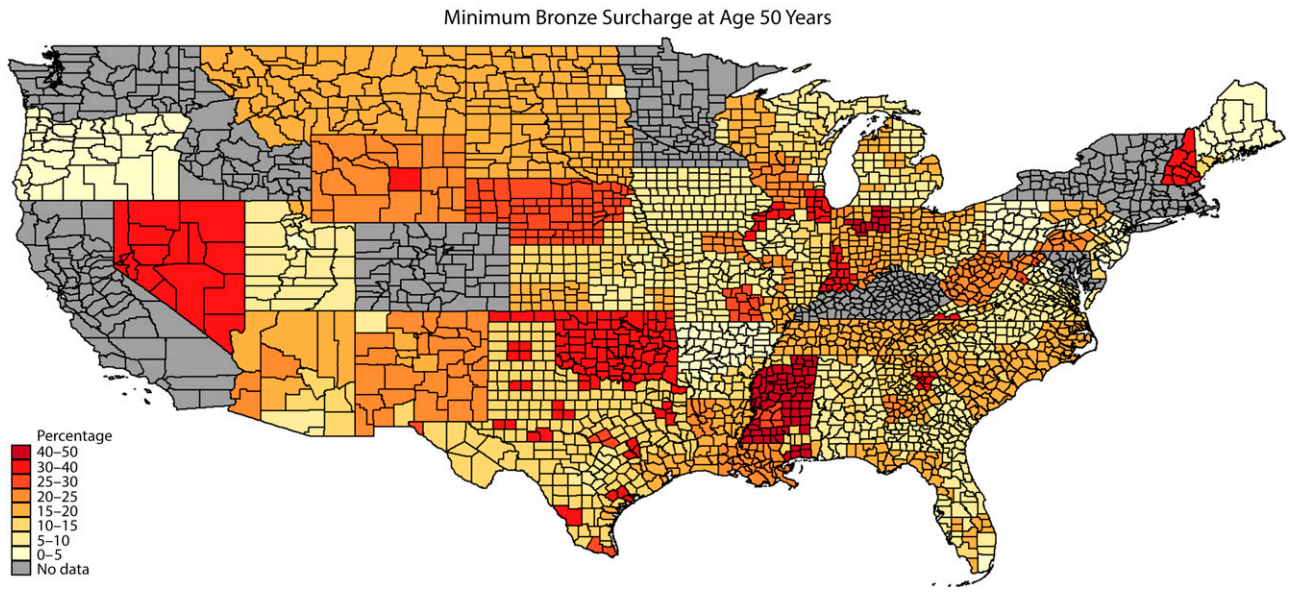
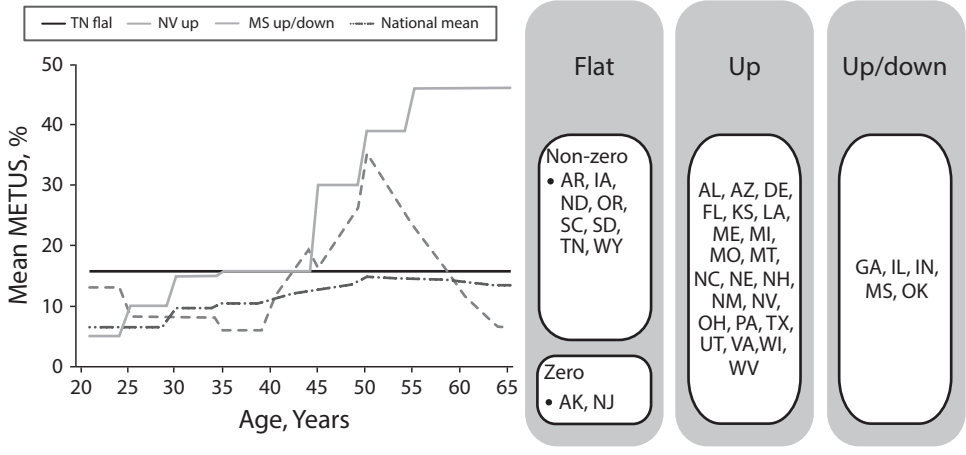


FIGURE 1—Minimum effective tobacco use surcharge (%) in bronze health insurance exchange plans for a 50-year-old person by US county in Federally Facilitated Marketplaces in 2015.

bronze premium)/minimum bronze premium.

The minimum effective tobacco use surcharge captures the difference in the shopping experience between tobacco users and nonusers. We used bronze plans in our calculations instead of cheaper catastrophic plans because the bronze plans are used to calculate affordability benchmarks for the purposes of enforcing the ACA's individual mandate provision. We used the number of persons aged 18 to 64 years in each county from the 2009 to 2013 American Community Survey as analytical weights to calculate the average minimum effective tobacco use surcharge at the state and national levels.[7] We used Stata/MP 11.2 for all data management and analysis.[8]



Note. Weighted by number of persons aged 18–64 years in each county.

FIGURE 2—Minimum effective tobacco use surcharge (METUS; %)-by-age in selected states for each representative METUS-by-age pattern and national mean METUS-by-age in 2015.

RESULTS

We found that tobacco surcharges for the least expensive bronze health insurance exchange plans varied greatly in magnitude and manner across age as well as within and between states. For example, Figure 1 (which plots the minimum effective tobacco use surcharge in each county) illustrates that a 50-year-old tobacco user in Oregon would pay about 2% more for the least expensive plan (before subsidies) than would a nonuser, whereas in neighboring Nevada, the same tobacco user would pay about 35% more for the least expensive plan than would a nonuser. Even within the same state, differences persist; a 50-year-old tobacco user in San Antonio, Texas, would pay 10% more, whereas that same person living in nearby College Station, Texas, would pay 32% more for the least expensive bronze plan.

In Figure 2, we identify and plot 3 representative minimum

effective tobacco use surcharge–by-age curves that describe common health insurance exchange pricing environments: flat, up, and up/down; and we categorize the 37 states in our data set by these 3 general patterns. The minimum effective tobacco use surcharge–by-age curves shown in Figure 2 aggregate the effect of the different age-dependent tobacco surcharge rating curves in each county of each state to present the average surcharge expected for each age of tobacco user. Nevada provides an example of an "up" curve, with a mean minimum effective tobacco use surcharge that was larger for older tobacco users than for younger tobacco users. In Tennessee, the mean minimum effective tobacco use surcharge remained nearly flat at nonzero values across all ages, whereas in New Jersey (which prohibited tobacco rating in the health insurance exchange) and Alaska, the mean minimum effective tobacco use surcharge was 0% across the age range ("flat"). In Mississippi, the mean minimum effective tobacco use surcharge increased until a peak at age 50 years before decreasing ("up/down").

Figure 2 also plots the mean minimum effective tobacco use surcharge among the 37 states with Federally Facilitated Marketplaces (national mean). The national mean remained flat at approximately 6.5% from age 21 to 29 years, increased to 9.5% at age 30 years, and then increased steadily to 14.8% by age 50 years. The larger changes occurred in years that were multiples of 5. After age 50 years, the average minimum effective tobacco use surcharge declined steadily, reaching 13.1% at age 65 years and older.

DISCUSSION

The observed variation in the minimum effective tobacco use surcharge may alter health insurance exchange enrollment behavior in significant ways. Many older tobacco users will pay a higher tobacco surcharge on top of, and as a proportion of, an already larger premium for the same plans as young tobacco users. In most cases, older tobacco users will face high premiums even after subsidies are taken into account. Furthermore, the prevalence of tobacco use is much higher among Americans who previously did not have health insurance coverage than among those with health insurance (in 2008, 32.5% and 16.8%, respectively).[9] Furthermore, on average, tobacco users tend to have lower income and employment, and the current dynamic will ensure that these individuals will be further financially burdened by the tobacco surcharge, even to the point that insurance through the health insurance exchange remains unaffordable even after subsidization.[10]

Little systematic evidence has been collected on the effect of tobacco surcharges on consumer behavior or health outcomes. Liber et al.[11] found suggestive evidence that tobacco surcharges could influence privately insured persons to report quitting tobacco use. However, because tobacco surcharges were administered without the ability to verify tobacco use, reported and actual numbers of tobacco users could differ dramatically. This limitation is common for tobacco surcharges; the penalty for misrepresenting tobacco use status in health insurance exchange enrollment is retroactive payment of the tobacco surcharge. Thus, an economically rational enrollee might be likely to misrepresent tobacco use and risk paying the surcharge at a later date rather than honestly self-identify as a tobacco user.

The ability to vary tobacco surcharges by age raises concerns that health insurers may try to use differential surcharges to entice younger, healthier tobacco users to sign up for their policies while discouraging older, unhealthy tobacco users from doing so. Privately insured younger tobacco users may actually cost less to insurers than nonusers,[4] whereas older tobacco users cost significantly more.[12] State rate review can identify the most egregious abuses of rate setting, but a goal of stopping all "cherry-picking" may prove difficult to achieve. Future research may determine whether enrollees facing higher effective minimum surcharges will be more likely to avoid purchasing health insurance altogether and endure the known harms of being uninsured to their mental and physical health.[13] ■

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Contributors

A. C. Liber conceptualized the study, collected and analyzed the data, and drafted the original brief. J. M. Drope, I. Graetz, and C. M. Kaplan assisted in designing the study. J. M. Drope, I. Graetz, T. M. Waters, and C. M. Kaplan edited the original brief and participated in the completion of the final brief.

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Human Participant Protection

There were no human participants in this study, so institutional review board approval was not required or sought.

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