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Tobacco Rating Issues and Options for California under the ACA*

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1. Issue Overview

Under the federal Affordable Care Act (ACA), the way health insurance is marketed and sold is poised to undergo fundamental changes. The ACA prohibits many factors health insurers currently use to price and condition the sale of health insurance, such as an individual's specific health condition or claims experience. However, the ACA allows health insurers to charge up to 50 percent more than standard rates for people who use tobacco. This premium surcharge would be paid entirely by the individual, and would mean highly disproportionate cost increases for lower income persons. Under the ACA, states can impose stricter standards and could choose to disallow tobacco rating entirely or limit the tobacco-rating factor to lesser amounts..

This issue brief explores the potential impact of tobacco rating in California's individual health insurance market, including unintended consequences that could result from the policy. Should California allow health plans and health insurers (health plans) in the state to charge higher premiums for tobacco users? Should California prohibit tobacco rating given the potential impacts discussed here, including significantly higher premium payments for low-income individuals? What are some reasonable alternatives short of a ban on tobacco rating, and what are their relative merits? This issue brief considers these questions and outlines options for consideration by California policymakers.

2. Background

a. Current Practice in California

There are no current state limits on the rating factors health plans can use in pricing most individual health coverage in California.[1] Health plans can generally deny coverage to someone seeking to purchase new individual coverage because of that individual's pre-existing health conditions or other potential health risks. If they accept someone for coverage, health plans can and typically do base premiums on specific characteristics of the individual and family such as a person's age (charging higher rates for older persons), geographic region and health status or health risk. Tobacco use is among the factors health plans use to decide who to cover and how much to charge them in the current California market.

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b. Federal ACA Context

The ACA establishes minimum federal rules that govern the entire individual (non-group) and small-group insurance markets, including coverage offered through health insurance exchanges established under the Act and coverage outside the exchanges. Effective January 1, 2014, no one can be denied health coverage due to their health status, and tobacco use is the only health-related factor that may be used in setting premiums.[2] While federal regulations to implement these provisions have not yet been issued, the ACA clearly states that states can choose to impose more restrictive rules, but cannot be less restrictive.[3] That is, with respect to marketwide rating rules, states may reduce the amounts by which a carrier may vary its rates, but cannot increase those amounts.

The ACA also provides for subsidies for eligible lower income people, in the form of federal tax credits that can be advanced to help them pay for health insurance. To qualify, individuals and families must have income between 100 percent and 400 percent of the federal poverty level (FPL) for their family size.[4] They must not be eligible for Medicare, Medicaid (Medi-Cal in California) or the Children's Health Insurance Program (Healthy Families in California), not be eligible for employer-sponsored coverage (unless they have to pay a high percentage of their income for the employer coverage)[5] and must purchase the non-group coverage through the Exchange.

The amount of the premium tax credit is based on the cost of a benchmark plan[6] less a sliding-scale contribution from the individual/family. The expected contribution increases with income, ranging from a low of 2 percent of income for people below 133 percent of FPL[7] to 9.5 percent of income for those between 300 percent and 400 percent of poverty. Eligible individuals can buy a more expensive plan than the benchmark plan, but if they do so, they must pay the entire additional premium cost above the benchmark amount.[8]

It is critical to note that the federal premium tax credit is based only on premiums before any additional charge for tobacco use. That is, the federal tax credit is *not* increased for people facing higher premiums due to a tobacco-rating factor. Therefore, regardless of income, tobacco users would need to pay the entire additional premium on their own.[9] As we illustrate in a later section, the application of a 50 percent premium factor would mean lower income tobacco users could face health insurance premiums that are prohibitively expensive relative to their incomes.

Proponents of a tobacco use rating factor such as that allowed under the ACA support it based on the following rationale:

- Tobacco use is a voluntary behavior that increases an individual's need for and use of medical services. Thus, tobacco users should bear the responsibility for paying the additional costs health insurers will bear for their coverage.

- If health plans are not allowed to increase premiums for tobacco users, the additional medical costs caused by tobacco use will be spread across all people with individual coverage, increasing premiums for those who are not tobacco users.

- An express and substantial premium charge for tobacco use can encourage tobacco users to quit, and discourage others from starting. By doing so, they would improve their own

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health and life expectancy, as well as that of others who would inhale their secondary smoke.

However, at the levels permitted in the ACA, the tobacco-rating factor could also have undesirable effects:

- Since the subsidies would not be adjusted for the tobacco rate increase, out-of-pocket premium costs would be greatly increased for lower income tobacco users, making health insurance unaffordable for these persons. And because higher percentages of lower income persons smoke, many low-income individuals eligible for the Exchange would face unaffordable premiums.

- Tobacco use is highly addictive and it is often very difficult for users to quit, especially those with the difficult life circumstances often faced by many low-income people. In the face of prohibitively expensive premiums, it is likely that many would instead forego health insurance. While taxes on tobacco products *per se* have been found to be effective in reducing consumption,[10] a tobacco-rating factor on health insurance may not be as effective because it is not as immediately related to the use of tobacco.

- Calculations based on available data indicate that a 50 percent increase in premiums for tobacco users could well considerably exceed the expected higher levels of health care costs caused by tobacco use.[11] Insurers might also use such a high tobacco-rating factor as an indirect way to charge more for people with expensive health conditions, such as mental disorders, who are much more likely to smoke. While charging higher premiums based on health conditions is prohibited under ACA rating rules, the tobacco-rating factor might be used as a legally permitted proxy for health status.[12]

3. California Implementation Impact

In California, the ACA tobacco-rating factor could substantially reduce the number of low- and modest-income currently uninsured individuals who would otherwise be expected to enroll in the California Health Benefit Exchange (Exchange). Such individuals who are eligible for premium tax credits (and not for Medi-Cal or Healthy Families) are expected to constitute most of the enrollment for the Exchange.

As shown in Table 1 below, nationally, more than one out of five adults in the premium tax credit eligible income range are current cigarette smokers, about double the rate of individuals who will not be eligible for a tax credit, those with incomes above 400 percent FPL.

While California's smoking rates are below national rates (12.1% in California, compared to 19.3% nationally in 2010[13]), lower income Californians are much more likely to smoke than higher income Californians, and may smoke at rates closer to national rates for low-income adults than the overall average rate comparison would suggest. Income-distribution data on California smokers is not available by percentage of poverty, but is available by dollar income. In 2008, 19.8 percent of Californians with household incomes under $20,000 were smokers, while only 7.8 percent of those with incomes over $150,000 were smokers.[14] (In 2008, for a single person, $20,000 was 192 percent of poverty, and for a family of four it was 94 percent.)

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In addition, as smoking rates declined among Californians over time, the reduction in smoking rates was less for lower income people: from 1990 to 2008, there was only a 12.7 percent reduction in smoking rates among adults under $20,000 per year, compared to a 37.7 percent reduction across all incomes.[15]

Table 1: Percentage of adults 18 years or older, by income levels, who are current cigarette smokers,* United States, 2010

Table 1 Smoking Prevalence by Income Percent of the Federal Poverty Level (FPL)	
Income as a Percent of FPL	Percent Who Smoke*
Less than 138%	28.0%
138-200%	23.3%
200-300%	21.7%
300-400%	17.8%
Above 400%	12.8%
Total	19.3%

Notes: The FPL ranges shown are based on self-reported family income and poverty thresholds published by the US Census Bureau, 2000-2010 (http://www.census.gov/hhes/www/poverty/threshld.html).

* Current smokers included adults who reported smoking ≥100 cigarettes in their lifetime and specified they currently smoked "every day" or "some days."

Source: Total: Centers for Disease Control and Prevention, "Vital Signs: Current Smoking among Adults Aged ≥18 Years, United States, 2005 – 2010," *Morbidity and Mortality Weekly Report*, September 9, 2011, http://www.cdc.gov/mmwr/pdf/wk/mm6035.pdf. By income: Unpublished tabulations from the National Health Interview Survey, United States—2010, provided by the Centers for Disease Control and Prevention's Office on Smoking and Health.

As shown in Table 2 below, smokers with lower incomes who are eligible for premium tax credits would generally face prohibitively high health insurance premiums under the maximum 50 percent tobacco-rating factor allowed by ACA. As noted earlier, this is because the additional premium charged for tobacco use is not included in the calculation of the tax credit. The table illustrates the cost for the benchmark silver plan (actuarial value=70%). A bronze plan (actuarial value=60%) would have a somewhat lower premium representing a somewhat lower percent of income, but it would also require much higher out-of-pocket costs for copayments and deductibles, especially for lower income individuals under 250 percent of poverty, who will qualify for additional federal cost-sharing subsidies *only* if they purchase a silver plan.[16]

For example, an average-age adult at 150 percent of poverty would see her premium contribution increase from $708 to $3,308 for an Exchange benchmark plan with a before-subsidy premium of $5,200. This would be 18.7 percent (rather than 4 percent) of her income. (And it would be

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56 percent of her income beyond the federal poverty-level income needed for basic necessities other than health care.) The schedule used to calculate ACA tax credits is constructed such that tax-credit recipients would all pay about the same proportion—12.0 percent to 14.3 percent—of their income above poverty. The largest impact would be on an older couple at 150 percent of poverty, who if subjected to the maximum smoking factor would face a premium equaling 48 percent of their total income and 143 percent of their income above the poverty level. In other words, payment of their health insurance premium increased for tobacco use would literally impoverish them. To the degree that the federal poverty level understates the costs of basic necessities in California, such premium levels would constitute an even greater burden on such people.

Table 2: Impact of ACA Tobacco-Rating Factor on Low-Income Adults

Table 2 **Estimated 2016 Annual Premium Payment** **for "Benchmark" Coverage** Persons Eligible for Premium Tax Credits thru the Exchange By Percent of Income and *Percent of Income in Excess of the FPL*						
Family Income	Without Tobacco Rating Factor			With Maximum Tobacco Factor under ACA		
Average-Age Single Adult Tobacco User						
150% FPL	$708	4.0%	*12.0%*	$3,308	18.7%	*56.1%*
250% FPL	$2,375	8.1%	*13.4%*	$4,975	16.9%	*28.1%*
500% FPL	$5,200	8.8%	*11.0%*	$7,800	13.2%	*16.5%*
Older Single Adult Tobacco Users over age 59						
150% FPL	$708	4.0%	*12.0%*	$5,908	33.4%	*100.1%*
Worst Case†: Impact on Older Couples Who Both Use Tobacco						
150% FPL	$952	4.0%	*12.0%*	$11,352	47.7%	*143.1%*

Notes: The tax-credit "benchmark" plan is the second lowest-cost "silver" plan available through the Exchange. Premium estimates are based on the Congressional Budget Office's estimate that, in 2016, the national average premium for the benchmark plan would be $5,200 for the average purchaser. Because premiums are age-rated, premiums for older purchasers (@ 59+) are expected to cost twice the average amount. And premiums for couples are assumed to be twice the premium for a single adult.

† The actual "worst case" would be at 139% FPL, just above the threshold for Medicaid eligibility.

Source: Illustrations by Institute for Health Policy Solutions based on U.S. Internal Revenue Code §36B and U.S. Public Health Service Act §2701, as enacted by ACA §1401 and §1201, respectively.

These double-digit percent-of-income costs mean that the maximum tobacco-rating factor permitted under the ACA would make coverage unaffordable for lower income tobacco users. The ACA expressly recognizes that a premium of more than 8 percent of income is not "affordable" and relieves individuals who would have to pay more than this amount for coverage from the individual "mandate" to obtain coverage.[17]

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Research has shown that participation in subsidized programs by low-income uninsureds falls below 2 percent of eligibles when premiums exceed 10 percent of income.[18] This indicates that very few lower income tobacco users would participate in coverage with a 50 percent premium surcharge, undermining a fundamental goal of the ACA to reduce the number of uninsured.

Further, such premium surcharges would undermine the goal of broad risk spreading across lower cost and higher cost individuals, particularly with respect to lower income Exchange participants.

Low-income individuals who have, or perceive themselves to be at high risk for, expensive medical conditions would be more likely to pay such tobacco-rated premiums than individuals who are healthier or view themselves as less likely to experience high health care expenses. The potential for this type of risk selection, a lower proportion of healthier people choosing to buy coverage than of people with higher health risks, would have a negative impact on the pool of individuals who buy coverage through the California Exchange and on the overall health care costs for Exchange enrollees.

4. Why it matters?

If the tobacco-rating factor is implemented in California as permitted under the ACA, it is very likely that:

- Most lower income tobacco users who not eligible for public or employer coverage would not have access to affordable coverage and would remain uninsured. This population represents up to one in five lower income individuals for whom substantial tax credits were intended to ensure such access—somewhere between 200,000 and 400,000 people out of the 1.4 to 2.0 million expected to receive tax credits in 2016.[19]

- Among lower income tobacco users, the Exchange and its participating health plans would realize enrollment of a significantly higher percentage of tobacco users with, or at high risk of, expensive medical conditions than of low cost tobacco users, such as younger users not yet experiencing serious longer term health effects of smoking.

- Because this severe adverse selection would occur among approximately one out of five people who were anticipated to constitute the core population for the Exchange, it could make participation in the Exchange less attractive to health plans, which are not required to participate in the Exchange.

- To the degree that risks are spread across the market via risk adjustment, it would also increase average premiums for all individual market participants.

5. Policy options and recommendations

To make coverage affordable for lower income tobacco users, and to prevent a related adverse selection problem for the Exchange, California could adopt rating rules which constrain or curtail the tobacco-rating factor. Under the ACA, whatever policy California adopts would have to apply across the individual market for coverage both inside and outside of the Exchange. (Note

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that rules and practices regarding the identification and adjudication of an individual's tobacco use are beyond the scope of this paper. They would logically be the same under any tobacco-use rating factor, and will presumably be addressed in forthcoming federal rules.)

One option would be to prohibit the use of a tobacco-rating factor. This would address the affordability, access and adverse-selection problems discussed above, but it would also eliminate responsibility for the medical-cost consequences of tobacco use, and remove the related cost incentive to quit.

Below are a range of options which would substantially mitigate potential affordability and adverse selection problems of the ACA tobacco-use rating factor while retaining cost responsibility and incentives for cessation of tobacco use. Table 3 illustrates the comparative effects of these alternatives and the ACA tobacco-rating factor premium payments. It shows the percent-of-income costs of these alternatives for the same family and income categories illustrated in Table 2. A more detailed table is provided in Appendix A.

Table 3: Impact of Alternatives to the ACA Tobacco-Rating Provision

Table 3
Impact of Alternative Tobacco-Rating Factors on
2016 Annual Premium Payments for "Benchmark*" Coverage
Persons Eligible for Premium Tax Credits thru the Exchange
By Percent of Income and *Percent of Income in Excess of the FPL*

Family Income	ACA 50% of total premium	Alt #1 50% of after-subsidy cost	Alt #2 20% of total premium	Alt #3 20% of after-subsidy cost	Alt #4 Max. $1,200 per year
Average-Age Single Adult Tobacco Users					
150% FPL	$3,308 *(18.7%)*	$1,062 *(6.0%)*	$1,748 *(9.9%)*	$850 *(4.8%)*	$1,908 *(10.8%)*
250% FPL	$4,975 *(16.9%)*	$3,562 *(12.1%)*	$3,415 *(11.6%)*	$2,850 *(9.7%)*	$3,575 *(12.1%)*
500% FPL	$7,800 *(13.2%)*	$7,800 *(13.2%)*	$6,240 *(10.6%)*	$6,240 *(10.6%)*	$6,400 *(10.8%)*
Older Single Adult Tobacco Users over age 59					
150% FPL	$5,908 *(33.4%)*	$1,062 *(6.0%)*	$2,768 *(15.8%)*	$850 *(4.8%)*	$1,908 *(10.8%)*
Worst Case†: Impact on Older Couples Who Both Use Tobacco					
150% FPL	$11,352 *(44.7%)*	$1,428 *(6.0%)*	$5,112 *(21.5%)*	$1,142 *(4.8%)*	$3,352 *(14.1%)*

Notes: For further description of alternatives, see text.

* The tax-credit "benchmark" plan is the second lowest-cost "silver" plan available through the Exchange. Premium estimates are based on the Congressional Budget Office's estimate that, in 2016, the national average premium for the benchmark plan would be $5,200 for the average purchaser. Because premiums are age-rated, premiums for older purchasers (59+) are expected to cost twice the average amount.

† The actual "worst case" would be at 139% FPL, just above the threshold for Medicaid eligibility.

Source: Illustrations by Institute for Health Policy Solutions based on U.S. Internal Revenue Code §36B and U.S. Public Health Service Act §2701, as enacted by ACA §1401 and §1201, respectively.

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ACA Tobacco-Rating Factor

Under the ACA, health plans may charge up to 50 percent more for a tobacco user than the standard premium for a non-tobacco user of the same age and geographic region. The tobacco-rating factor must be applied uniformly to all purchasers in the individual, non-group market, inside and outside the Exchange. As stated earlier, the application of the ACA tobacco-rating factor substantially increases the premium contribution for individuals eligible for premium tax credits in the Exchange because the tax credits do not apply to or reduce the amount of the tobacco-rating increase.

Alternative 1 – Apply the ACA tobacco-rating factor to the subsidized premium amount

Alternative 1 would apply the ACA 50 percent tobacco-rating factor to the after-subsidy premium for the plan in which the individual enrolls. The authors believe states would be legally able to adopt such a rating rule under the ACA, if consistently applied across the market,[20] because it is more restrictive than the ACA tobacco-rating factor of 50 percent.

Alternative 1 would avoid disproportionate cost increases for lower income persons, but would also mean that most smokers would still face benchmark (silver) plan costs of well over 10 percent of income and may not have access to any plan for less than the 8-percent-of-income ACA threshold for an affordable premium.[21] Such an after-subsidy rating factor should be at least as administrable as the ACA approach, because a health plan would apply the same percentage factor to the amount billed to any given subscriber. Health plans can and do already vary individual premiums by different rating factors and should be able to administer this alternative in a similar manner. Note that the Exchange would also add the percentage factor to information on the after-tax subsidy amount the tobacco user would pay for different plan choices. It should be no more difficult to implement this than the ACA percent-of-total-premium approach.[22]

Note that under Alternative 1, health plans would receive lower total premium payments for smokers who are tax-credit recipients than from other smokers. Thus, qualified health plans (QHPs) enrolling significant numbers of tax-credit recipients in the Exchange would realize lower total premium payments for tobacco users than would individual market health plans that do not participate in the Exchange.

However, compared to the original ACA provision, this approach (and the other alternatives that follow) should substantially reduce the risk of severe adverse selection by low-income tobacco users. Therefore, adopting such an alternative should make Exchange participation more rather than less attractive to plans, and should reduce rather than increase premiums for non-smokers relative to the ACA provision.

Alternative 2 – Apply a lower tobacco-rating factor to the total premium (20% v. 50%)

Alternative 2 would simply reduce the 50 percent ACA tobacco-rating factor to 20 percent, which seems clearly permissible under the ACA. However, a typical individual tax-credit recipient with an income of 150 percent of poverty would still have to pay about 10 percent of income to obtain a benchmark plan. An older couple who both use tobacco would have to pay

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21.5 percent of their income. In other words, this alternative does not solve either the affordability or the risk-selection problem for lower income tobacco users.

Alternative 3 – Apply a lower rating factor (e.g., 20%) to the premium after subsidy

Alternative 3 combines the features of Alternatives 1 and 2, and appears allowable under the ACA for the same reason as Alternative 1. Table 3 illustrates the cost effects if health plans may charge up to 20 percent more for a tobacco user, and the additional charge applies to the after-subsidy premium actually paid by the individual purchaser.

This alternative would address the affordability and risk-profile problems for tobacco users, and tobacco users of different incomes would bear the same proportionate costs. However, because lower income tobacco users would not pay the full additional costs associated with their smoking, non-tobacco-users could also bear some proportion of the medical care costs associated with tobacco use in the form of higher overall premiums for Exchange and (given risk-spreading provisions under ACA) other individual coverage.

> Note that some percentage limit other than 20 percent could be chosen. Appendix B presents information on the dollar and percent-of-income amounts that would be paid by individuals for the Exchange benchmark plan under limits that vary from 10 to 30 percent. We note that 20 percent would keep such costs under 8 percent of income for those under 200 percent of poverty, and under 10 percent of income for those under 250 percent of poverty. While a lower limit such as 10 percent would also do so, the small marginal cost difference to the individual and revenue difference to the health plan may not be worth the administrative burdens associated with such a tobacco-rating factor.

Alternative 4 – Cap the dollar amount of the tobacco-rating factor

In this alternative, health plans could charge a tobacco user no more than the lesser of 50 percent of the premium, or $1,200 more per year. Except where the premium is less than $2,400 (e.g., for a young adult obtaining a high-deductible plan), this would be the uniform additional charge across all purchasers in the individual market, whether or not they are tax-credit recipients in the Exchange or higher income individuals with coverage inside or outside the Exchange.

This option seems clearly allowable since the ACA allows states to adopt more restrictive market-wide rating rules and would greatly mitigate the cost for most smokers, limiting the potential for adverse selection. But it would mean that higher income smokers would generally pay much less than the ACA's 50 percent of premium, while low-income tax-credit smokers at 150 percent of poverty would still see their costs for the benchmark silver plan more than double to 10.8 percent of income.

Recommended Alternative rating factor:

Alternative 3 is recommended because it makes coverage affordable for lower income tobacco users while requiring them to bear the same proportionate responsibility and incentives to quit as higher income tobacco users.

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Related issue: coverage of cessation services

Health reform seeks to reduce tobacco use both as a way to reduce unnecessary health care costs as well as to improve the health status of individual users and others who suffer from secondary exposure. Therefore, in addition to any financial incentives, it would also be important to assist individuals who do want to quit but find doing so difficult. Data presented earlier shows that tobacco use persists among lower income populations and persons with mental health conditions. This is despite the seemingly compelling disincentive of well-documented, well known and significant morbidity and mortality effects of tobacco use.[23]

Health plans should cover counseling and drugs that assist individuals in tobacco-use cessation—especially if health plans charge more for tobacco use. Even though many individuals may not remain enrolled in their current health plan long enough for that plan to realize the longer-term savings in medial costs, their future health plans will realize this savings. Thus, a system-wide requirement for health plans to cover these services seems fully justified, both on health and economic grounds.

Smoking cessation counseling has an "A" rating from the U.S. Preventive Services Task Force,[24] and is therefore one of the preventive services already required to be covered by group and individual health plans under the ACA.[25] The ACA also includes these preventive services in the mandatory essential health benefit categories for individual and small-group coverage.[26] But the Task Force's wording is not very specific.[27] Further guidance is needed but has not yet been forthcoming. Even though employer plans are already technically required to cover this service category, but perhaps due to this lack of specificity, many employer plans reportedly do not do so.[28]

It therefore seems important that California either select an essential health benefits benchmark plan whose benefits definitively include these services (or, if not included in that plan, add and define this ACA-required service category), and clearly delineate these service categories as essential health benefits in applicable guidelines .[29]

6. Future issues for research - Policy questions

An updated analysis of the direct medical costs of smoking, and published findings that outline the proportionate impact smoking has on various respective populations' health care use and costs, would be helpful. The methodology used in earlier estimates for the California Department of Health services appears to be well-suited for this purpose.[30] Further, alternative tobacco-use rating policies adopted by different states under the ACA will provide an opportunity to analyze their respective effects on individuals' participation in coverage, selection effects on the risk profile of enrollees, as well as potential effects on tobacco use and cessation. Such research would be very helpful to future consideration of these issues and to identification of effective solutions.

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Notes

[1] California law does provide for various continuation coverage programs, consistent with and in addition to federal law, such as coverage for those under the Health Insurance Portability and Accountability Act, known as HIPAA coverage, and coverage following the loss of a job or other life changes under the Consolidated Omnibus Budget Reconciliation Act, or COBRA. These programs require coverage to be continued if a person is eligible, regardless of their individual health history, and have some limits on the rating factors health plans must use.

[2] The only other rating factors allowed are the family coverage category, age (limited to at most a 3-to-1 ratio), and geographic rating area. [Section 2701 of the Public Health Service Act (PHSA), as added by ACA §1201.]

[3] PHSA § 2724 says that States rules cannot "prevent the application of" a federal requirement.

[4] Because people will be eligible for Medi-Cal up to 138 percent of poverty, the lower end of this income range is applicable primarily to legal immigrants who have not been in the United States long enough to qualify for Medi-Cal. These can qualify for a premium tax credit even if their income is less than 100 percent of the poverty level.

[5] If the employer-sponsored insurance would cost more than 9.5 percent of the family's income, the individual or family can purchase non-group Exchange coverage using a premium-tax credit.

[6] The benchmark plan for tax-credit purposes will be that coverage product available to the family or individual through the Exchange that is the second-lowest-cost offering in the ACA coverage tier referred to as "silver-level" coverage. The ACA establishes five coverage tiers—platinum, gold, silver, bronze and catastrophic—based on the expected value of the benefits covered. The silver level is defined to provide benefits equal to 70 percent actuarial value, meaning that the plan is estimated to cover 70 percent of the health care expenses of a standard population.

[7] At 133 percent of poverty, the expected contribution jumps to 3 percent of income and increases linearly thereafter to specified percentage rates at 150 percent (4.0%), 200 percent (6.3%), 250 percent (8.05%) and 300 percent (9.5%) of poverty.

[8] On the other hand, if they choose a less-expensive plan, they pay less.

[9] Internal Revenue Code §36B(b)(3)(C), as added by ACA §1401.

[10] See, e.g., Chaloupka, FJ, "Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine and Tobacco Research* 1(Suppl 1):S105-9, 1999.

[11] Available data indicates that smokers' health care costs are higher than nonsmokers, but (with one exception) published studies do not directly estimate relative annual per capita health care expenditures for smokers v. non-smokers under age 65. Instead, studies tend to focus on aggregate expenditures attributable to smoking/tobacco use or on the dollar increase in lifetime health care spending for smokers, including expenditures after age 65. Some studies estimate excess per-capita costs for smokers in dollar terms but do not supply the relevant per-capita cost for non-smokers. The exception is a Dutch study which found that the difference in per-capita costs between smokers and non-smokers varied by age but reached a *maximum* of 40 percent among 65-to-74-year-old men (and only 25 percent among women). Jan J. Barendregt, M.A., Luc Bonneux, M.D., and Paul J. van der Maas, Ph.D., "The Health Care Costs of Smoking," *N Engl J Med* 1997; 337:1052-1057, October 9, 1997. <http://www.nejm.org/doi/full/10.1056/NEJM199710093371506>

Based on earlier research (cited in their analysis), Tobacco-Free Kids estimates 5-year excess health care costs for smokers to be about $4,200 in 2004 dollars, or about $840 per year. <http://www.tobaccofreekids.org/research/factsheets/pdf/0327.pdf> In 2004, average total health care

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expenditures for adults were just under $4,000 with the elderly included and about $3,050 with the elderly excluded, according to the Medical Expenditure Panel Survey. [Authors' analysis using the online MEPSnet Query tool, Analysis Variable: TOTEXP04 - TOTAL HEALTH CARE EXP 04 Records Used: AGE GE 18 and AGE LT 65.] Thus, the additional cost for smokers would range from 21 to 27.5 percent. (Per-capita estimates of overall personal health care spending using National Health Expenditure data are higher than $4,000 in 2004, which would reduce the estimated percentage mark-up for smokers even further.)

Estimates we developed using the U.S. Centers for Disease Control and Prevention's online Smoking-Attributable Mortality, Morbidity, and Economic Costs calculator <https://apps.nccd.cdc.gov/sammec/exp_comp.asp> suggested increased per-capita costs for California smokers in the range of 40-50 percent, but these calculations include costs for those age 65 and older, who are covered by Medicare, not through the Exchange.

[12] Many individuals who have mental health conditions could thus be discouraged from purchasing coverage as a result of the higher premium for their tobacco use. For example, 38.1 percent of those with serious psychological distress smoke, as do 46.4 percent of those with bipolar disorder and 59.1 percent of adults with schizophrenia. Annette K. McClave et al., "Smoking Characteristics of Adults with Selected Lifetime Mental Illnesses: Results from the 2007 National Health Interview Survey," *American Journal of Public Health* 100:12 (2010), quoted in Legacy, *A Hidden Epidemic: Tobacco Use and Mental Illness*, June 2011, http://www.legacyforhealth.org/PDF/A_Hidden_Epidemic.pdf.

[13] Centers for Disease Control and Prevention, "Vital Signs: Current Smoking among Adults Aged ≥18 Years, United States, 2005 – 2010," *Morbidity and Mortality Weekly Report*, September 9, 2011, <http://www.cdc.gov/mmwr/pdf/wk/mm6035.pdf.> The national rate comes from the 2010 National Health Interview Survey. The smoking rate for California comes from the 2010 Behavioral Risk Factor Surveillance System survey. California's own survey, the California Tobacco Survey, produces slightly different results. (See next note.)

[14] California Department of Public Health, "Two Decades of the California Tobacco Control Program: California Tobacco Survey, 1990 – 2008," December 2010. Table A.2.1. The statewide smoking rate in this data source is 11.6 percent in 2008.

[15] *Ibid.*

[16] Federal cost-sharing subsidies improve the actuarial value of the silver plan from 70% to 94% for people up to 150 percent of poverty, to 87% between 150 percent and 200 percent of poverty, and (only minimally) to 73% between 200 percent and 250 percent of poverty.

[17] The "individual mandate" is presently under review by the U.S. Supreme Court and may be ruled unconstitutional. If it is, then people will make their own judgment about whether having health insurance is worth the premium they would be required to pay, and regardless of how much that is will not be subject to a tax penalty if they remain uninsured.

[18] Leighton Ku and Teresa A. Coughlin, "The Use of Sliding Scale Premiums in Subsidized Insurance Programs," The Urban Institute, March 1997. <http://www.urban.org/url.cfm?ID=406892>

[19] Exchange enrollment with subsidies in 2016 is expected to be between 1.4 million (under a "base scenario") and 2.0 million (under an "enhanced scenario" with greater outreach efforts). Ken Jacobs *et al.*, "Nine Out of Ten Non-Elderly Californians Will Be Insured When the Affordable Care Act is Fully Implemented," *Research Brief*, UCLA Center for Health Policy Research and UC Berkeley Labor Center, June 2012, <http://www.healthpolicy.ucla.edu/pubs/files/calsim_Exchange1.pdf>.

[20] We presume that federal regulations will require health plans that elect to impose a tobacco-use rating factor will be required to use the same factor both in and outside the Exchange.

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[21] Based on their relative actuarial values (AV), the premium for bronze plan (AV=60%) should be roughly 6/7=86 percent of the premium for a silver plan (AV=70%).

[22] Under ACA implementing rules, the Exchanges will also determine and inform the individual of his premium cost for the chosen plan, and convey to the federal government the the advance tax credit amount to be paid to the plan by the IRS. Also note that the California Health Benefit Exchange could make it an option for an individual to pay the Exchange instead, which would mean that the Exchange would bill and collect the individual for the after subsidy premium amount.

[23] For example, the U.S. Centers for Disease Control and Prevention's online Smoking-Attributable Mortality, Morbidity, and Economic Costs system <https://apps.nccd.cdc.gov/sammec/edit_risk_data.asp> indicates that male smokers have a 17.1 times higher risk than non-smokers of contracting bronchitis or emphysema and a 23.3 times higher risk of contracting cancer of the trachea, lung or bronchus.

[24] *USPSTF A and B Recommendations*. August 2010. U.S. Preventive Services Task Force. <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>

[25] Section 2713 of the Public Health Service Act, as added by section 1001 of the ACA.

[26] ACA section 1302(b)(I) and associated regulatory guidance.

[27] The complete recommendation reads, "The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products."

[28] In 2011, only 31 percent of small firms (3-199 workers) and 63 percent of large firms that offered health benefits offered smoking cessation as a wellness program. The Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits: 2011 Annual Survey,* Exhibit 12.3.

[29] As of this writing, state legislation is pending. SB 951 (Hernandez) and AB 1453 (Monning) would designate the Kaiser Foundation Health Plan Group HMO thirty-dollar ($30) deductible plan contract as the benchmark plan for essential health benefits in California. According to an analysis of potential benchmark options prepared for the California Health Benefit Exchange, the Kaiser plan under consideration does cover tobacco cessation counseling and cessation medications. To review the Milliman analysis and comparison, go to http://www.healthexchange.ca.gov/FederalGuidance/.

[30] Max W, Rice DP, Zhang X, Sung H-Y, Miller L. *The Cost of Smoking in California, 1999,* Sacramento, CA: California Department of Health Services, 2002

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APPENDIX A: Impact of Alternative Tobacco-Rating Factors by Income Relative to FPL

Using Average $5,200 (Age-Rated) Premium for Single Coverage for a Tax-Credit "Benchmark" Plan* in 2016

	Without Tobacco Rating Factor		With Maximum Tobacco Factor under ACA		Alternative Approach #1 (Maximum 50% increase in after-subsidy premium)		Alternative Approach #2 (Reduce Maximum ACA Rate-Up from 50% to 20%)		Alternative Approach #3 (Maximum 20% increase in after-subsidy premium)		Alternative Approach #4 (Max. $1200 per year Additional Charge)	
Family Income %FPL	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income
Impact on Average-Age Single Adult Smokers												
150%	$708	4.0%	$3,308	18.7%	$1,062	6.0%	$1,748	9.9%	$850	4.8%	$1,908	10.8%
200%	$1,487	6.3%	$4,087	17.3%	$2,230	9.5%	$2,527	10.7%	$1,784	7.6%	$2,687	11.4%
250%	$2,375	8.1%	$4,975	16.9%	$3,562	12.1%	$3,415	11.6%	$2,850	9.7%	$3,575	12.1%
300%	$3,363	9.5%	$5,963	16.8%	$5,045	14.3%	$4,403	12.4%	$4,036	11.4%	$4,563	12.9%
350%	$3,924	9.5%	$6,524	15.8%	$5,885	14.3%	$4,964	12.0%	$4,708	11.4%	$5,124	12.4%
400%	$4,484	9.5%	$7,084	15.0%	$6,726	14.3%	$5,524	11.7%	$5,381	11.4%	$5,684	12.0%
450%	$5,200	9.8%	$7,800	14.7%	$7,800	14.7%	$6,240	11.8%	$6,240	11.8%	$6,400	12.1%
500%	$5,200	8.8%	$7,800	13.2%	$7,800	13.2%	$6,240	10.6%	$6,240	10.6%	$6,400	10.8%
550%	$5,200	8.0%	$7,800	12.0%	$7,800	12.0%	$6,240	9.6%	$6,240	9.6%	$6,400	9.9%
Impact on Low-Income Older Single Adult Smokers (e.g., over age 59)												
150%	$708	4.0%	$5,908	33.4%	$1,062	6.0%	$2,788	15.8%	$850	4.8%	$1,908	10.8%
200%	$1,487	6.3%	$6,687	28.3%	$2,230	9.5%	$3,567	15.1%	$1,784	7.6%	$2,687	11.4%
250%	$2,375	8.1%	$7,575	25.7%	$3,562	12.1%	$4,455	15.1%	$2,850	9.7%	$3,575	12.1%
300%	$3,363	9.5%	$8,563	24.2%	$5,045	14.3%	$5,443	15.4%	$4,036	11.4%	$4,563	12.9%
350%	$3,924	9.5%	$9,124	22.1%	$5,885	14.3%	$6,004	14.5%	$4,708	11.4%	$5,124	12.4%
400%	$4,484	9.5%	$9,684	20.5%	$6,726	14.3%	$6,564	13.9%	$5,381	11.4%	$5,684	12.0%
450%	$10,400	19.6%	$15,600	29.4%	$15,600	29.4%	$12,480	23.5%	$12,480	23.5%	$11,600	21.8%
500%	$10,400	17.6%	$15,600	26.4%	$15,600	26.4%	$12,480	21.2%	$12,480	21.2%	$11,600	19.7%
"Worst Case": Impact on Low-Income Older Couple (e.g., over age 59) Who Both Smoke												
150%	$952	4.0%	$11,352	47.7%	$1,428	6.0%	$5,112	21.5%	$1,142	4.8%	$3,352	14.1%
200%	$1,487	6.3%	$11,887	50.4%	$2,230	9.5%	$5,647	23.9%	$1,784	7.6%	$3,887	16.5%
250%	$2,375	8.1%	$12,775	43.3%	$3,562	12.1%	$6,535	22.2%	$2,850	9.7%	$4,775	16.2%
300%	$3,363	9.5%	$13,763	38.9%	$5,045	14.3%	$7,523	21.3%	$4,036	11.4%	$5,763	16.3%
350%	$3,924	9.5%	$14,324	34.7%	$5,885	14.3%	$8,084	19.6%	$4,708	11.4%	$6,324	15.3%
400%	$4,484	9.5%	$14,884	31.5%	$6,726	14.3%	$8,644	18.3%	$5,381	11.4%	$6,884	14.6%
450%	$20,800	39.2%	$31,200	58.8%	$31,200	58.8%	$24,960	47.0%	$24,960	47.0%	$23,200	43.7%
500%	$20,800	35.3%	$31,200	52.9%	$31,200	52.9%	$24,960	42.3%	$24,960	42.3%	$23,200	39.3%

* The tax-credit "benchmark" plan is the second lowest-cost "silver" plan available through the Exchange. The $5,200 estimate is from the Congressional Budget Office.

APPENDIX B: Impact of Variations on Tobacco-Rating Alternative #3, by Income Relative to FPL

[Using Average $5,200 (Age-Rated) Premium for Single Coverage for a Tax-Credit "Benchmark" Plan* in 2016]

	Without Tobacco Rating Factor		Alternative Approach #3b (Maximum 10% increase in after-subsidy premium)		Alternative Approach #3c (Maximum 15% increase in after-subsidy premium)		Alternative Approach #3 (Maximum 20% increase in after-subsidy premium)		Alternative Approach #3d (Maximum 25% increase in after-subsidy premium)		Alternative Approach #3e (Maximum 30% increase in after-subsidy premium)	
Family Income %FPL	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income	Individual's Payment for "Benchmark" Plan *	Premium Paid as a Percent of Income
Impact on Average-Age Single Adult Smokers												
150%	$708	4.0%	$779	4.4%	$814	4.6%	$850	4.8%	$885	5.0%	$920	5.2%
200%	$1,487	6.3%	$1,635	6.9%	$1,710	7.2%	$1,784	7.6%	$1,859	7.9%	$1,933	8.2%
250%	$2,375	8.1%	$2,612	8.9%	$2,731	9.3%	$2,850	9.7%	$2,968	10.1%	$3,087	10.5%
300%	$3,363	9.5%	$3,699	10.5%	$3,867	10.9%	$4,036	11.4%	$4,204	11.9%	$4,372	12.4%
350%	$3,924	9.5%	$4,316	10.5%	$4,512	10.9%	$4,708	11.4%	$4,904	11.9%	$5,101	12.4%
400%	$4,484	9.5%	$4,932	10.5%	$5,157	10.9%	$5,381	11.4%	$5,605	11.9%	$5,829	12.4%
450%	$5,200	9.8%	$5,720	10.8%	$5,980	11.3%	$6,240	11.8%	$6,500	12.2%	$6,760	12.7%
500%	$5,200	8.8%	$5,720	9.7%	$5,980	10.1%	$6,240	10.6%	$6,500	11.0%	$6,760	11.5%
550%	$5,200	8.0%	$5,720	8.8%	$5,980	9.2%	$6,240	9.6%	$6,500	10.0%	$6,760	10.4%
Impact on Low-Income Older Single Adult Smokers (e.g., over age 59)												
150%	$708	4.0%	$779	4.4%	$814	4.6%	$850	4.8%	$885	5.0%	$920	5.2%
200%	$1,487	6.3%	$1,635	6.9%	$1,710	7.2%	$1,784	7.6%	$1,859	7.9%	$1,933	8.2%
250%	$2,375	8.1%	$2,612	8.9%	$2,731	9.3%	$2,850	9.7%	$2,968	10.1%	$3,087	10.5%
300%	$3,363	9.5%	$3,699	10.5%	$3,867	10.9%	$4,036	11.4%	$4,204	11.9%	$4,372	12.4%
350%	$3,924	9.5%	$4,316	10.5%	$4,512	10.9%	$4,708	11.4%	$4,904	11.9%	$5,101	12.4%
400%	$4,484	9.5%	$4,932	10.5%	$5,157	10.9%	$5,381	11.4%	$5,605	11.9%	$5,829	12.4%
450%	$10,400	19.6%	$11,440	21.5%	$11,960	22.5%	$12,480	23.5%	$13,000	24.5%	$13,520	25.5%
500%	$10,400	17.6%	$11,440	19.4%	$11,960	20.3%	$12,480	21.2%	$13,000	22.0%	$13,520	22.9%
"Worst Case": Impact on Low-Income Older Couple (e.g., over age 59) Who Both Smoke												
150%	$952	4.0%	$1,047	4.4%	$1,095	4.6%	$1,142	4.8%	$1,190	5.0%	$1,238	5.2%
200%	$1,487	6.3%	$1,635	6.9%	$1,710	7.2%	$1,784	7.6%	$1,859	7.9%	$1,933	8.2%
250%	$2,375	8.1%	$2,612	8.9%	$2,731	9.3%	$2,850	9.7%	$2,968	10.1%	$3,087	10.5%
300%	$3,363	9.5%	$3,699	10.5%	$3,867	10.9%	$4,036	11.4%	$4,204	11.9%	$4,372	12.4%
350%	$3,924	9.5%	$4,316	10.5%	$4,512	10.9%	$4,708	11.4%	$4,904	11.9%	$5,101	12.4%
400%	$4,484	9.5%	$4,932	10.5%	$5,157	10.9%	$5,381	11.4%	$5,605	11.9%	$5,829	12.4%
450%	$20,800	39.2%	$22,880	43.1%	$23,920	45.0%	$24,960	47.0%	$26,000	49.0%	$27,040	50.9%
500%	$20,800	35.3%	$22,880	38.8%	$23,920	40.5%	$24,960	42.3%	$26,000	44.1%	$27,040	45.8%

* The tax-credit "benchmark" plan is the second lowest-cost "silver" plan available through the Exchange. The $5,200 estimate is from the Congressional Budget Office.