District of Columbia Health Benefit Exchange Authority

March 20, 2013

Tobacco Rating

Legislation and Context

Section 2701(a)(1)(A)(vi) of the PHS Act, as revised by section 1201 of the Affordable Care Act (ACA), limits the variation in premium rating for tobacco use to a maximum of 1.5 to 1. With respect to family coverage under a group health plan or health insurance coverage, the tobacco rating variations shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage. The advanced premium tax credit (APTC) for low income purchasers of health insurance does **not** apply to premium tobacco surcharge under the ACA. Each state must determine if it will allow health insurance issuers to utilize a tobacco use surcharge equal to the maximum allowed under the ACA, allow for a modified rating, prohibit a tobacco rating, or leave the decision to apply the surcharge to carriers. Federal rule uses the following definition of tobacco use, "four or more times on average over the past six months." To date, there has been no consensus nationwide on what approaches states will take on this issue. Summarized from David Dillon's "Report on Tobacco Rating Issues in Arkansas under the Affordable Care Act", the factors states are considering in making their decision include:

- Non-tobacco users subsidizing the medical costs (i.e., health insurance premiums) of tobacco users;
- Federal tax credits are not adjusted for the tobacco surcharge, thus creating affordability issues for low income persons;
- The maximum ACA surcharge of 50 percent may exceed the expected health care costs of tobacco users;
- Insurers could use a high tobacco-rating factor as an indirect underwriting factor for other conditions;
- The possibility that a large tobacco surcharge could encourage tobacco cessation;
- The voluntary nature of tobacco use.

According to the Centers for Disease Control and Prevention (CDC):[1]

> "In the District of Columbia, the percentage of adults (ages 18+) who currently smoke cigarettes was 20.8% in 2011. Across all states and D.C., the prevalence of cigarette smoking among adults ranged from 11.8% to 29.0%. The District of Columbia ranked 22nd among the states."

The District of Columbia (DC) currently allows carriers to use tobacco as a factor in medical underwriting.

[1] Centers for Diseases Control and Prevention, 2011
http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/pdfs/states/dc.pdf

State Rating Factors Overview

The following chart summarizes current rating factors that states allow in their health insurance markets.

Table 1. Individual Market Rate Restrictions[2]

	Limits on Rating?	Types of Rating Restrictions?	Rating Allowed for Health Status?	Rating Allowed for Age?	Rating Allowed for Gender?	**Rating Allowed for Tobacco Use?**	Rating Allowed for Industry?
Number of States	19		44	49	37	**46**	38
District of Columbia	Yes	Rate Bands	Yes	Yes	No	**Yes**	Yes

Selected State Policies and Recommendations

Arkansas

An actuarial report[3] commissioned by the Health Benefit Exchange Partnership Division (HBEPD) of the Arkansas Insurance Department (AID) reviewed the tobacco rating issue. This report considers the following seven alternatives:

- Alternative 1 – Apply the ACA 50% tobacco use surcharge to the subsidized premium amount.
- Alternative 2 – Apply a lower (e.g. 20%) tobacco use surcharge to the total premium amount
- Alternative 3 – Apply the 20% tobacco use surcharge to the subsidized premium amount.
- Alternative 4 – Apply a 10% tobacco use surcharge to the total premium amount.
- Alternative 5 – Apply the 10% tobacco use surcharge to the subsidized premium amount.
- Alternative 6 – Apply a tobacco use surcharge that increases with age
- Alternative 7 – Prohibit the use of a tobacco surcharge

The report recommends that the **Arkansas Insurance Department implement a tobacco surcharge that is less than the maximum allowable by the ACA to help alleviate significant impacts to both tobacco users and non-tobacco users**. The reasons for the recommendation include:

- A limited surcharge would be better aligned with the expected excess cost of tobacco-related care;

[2] State Health Facts, 2012.http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7&sort=1096
[3] Dillon, David, "Report on Tobacco Rating Issues in Arkansas Under the Affordable Care Act" Lewis and Ellis Actuaries and Consultants" February, 2013.

- Coverage would be more affordable for lower income tobacco users while requiring them to bear a significant portion of financial responsibility;
- A tobacco surcharge alternative can be structured such that the expected average premium change for non-tobacco users would be less than 2.5%.

It should be noted that federal regulations prohibit applying surcharges to subsidized premium amounts noted above in alternatives 1, 3, and 5.

California

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. An issue brief[4] by Rick Curtis and Ed Neuschler of the Institute for Health Policy Solutions (IHPS) for the California Healthcare Foundation considered four alternatives for the tobacco rating issue in the state of California. The alternatives considered included:

- Alternative 1 – Apply the ACA tobacco-rating factor to the subsidized premium amount
- Alternative 2 – Apply a lower tobacco-rating factor to the total premium (20% v. 50%)
- Alternative 3 – Apply a lower rating factor (e.g., 20%) to the premium after subsidy
- Alternative 4 – Cap the dollar amount of the tobacco-rating factor

The IHPS recommended Alternative 3 because it makes coverage more affordable for lower income tobacco users while requiring them to bear the same proportionate responsibility and incentives to quit as higher income tobacco users. As of March12, the Assembly Committee on Health X1 is reviewing the issue of tobacco rating and noted the following[5]:

> "Provisions of the ACA are intended to address affordability of health care coverage. Subsidies for purchasing health insurance will be available in the Exchange for some individuals whose coverage costs exceed a certain percentage of their income, and other individuals will be exempt from the individual mandate if costs exceed a specified percentage of their income (8%). Surcharges associated with tobacco use and standards-based wellness incentive programs could make coverage unaffordable for some populations and take them out of the health insurance market altogether. Alternatively, such programs could drive unhealthy individuals into the Exchange where subsidies may be available. Taking tobacco rating as an example, a non-smoker with family income of $17,700 would be charged $5,200 annual premium for a tax-credit benchmark plan in the Exchange. With federal subsidies available through the Exchange, this individual would pay a $708 premium per year. A similarly situated smoker would have to pay a tobacco surcharge (50% of premium or $2,600) in addition to the $708 for a total premium (minus the subsidies) of $3,308 which represents 18.7% of his or her income. In this example, the smoker could opt out of the mandate to purchase health insurance because the product is no longer affordable. **While the ACA allows for tobacco rating, this bill does not include tobacco rating as a factor for determining premium rates."**

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[4] Curtis, Rick and Neuschler , Ed, "Tobacco Rating Issues and Options for California under the ACA" Institute for Health Policy Solutions June, 2012.

[5] California Assembly Committee on Health X1 Bill Analysis on Health Care Coverage, March 2013. http://leginfo.ca.gov/pub/13-14/bill/sen/sb_0001-0050/sbx1_2_cfa_20130308_164138_asm_comm.html

It should be noted that federal regulations prohibit applying surcharges to subsidized premium amounts noted above in alternative 1,

Connecticut

The Connecticut Health Insurance Exchange Joint Advisory Committee Meeting Review of (Revised) Staff Recommendation for QHP Certification[6] recommends that **the Exchange prohibit QHP carriers to include tobacco use as a rating factor in the Individual Exchange**. They also noted that Connecticut General Statute 38a -567 excludes tobacco use as a rating factor for small groups.

Massachusetts

Massachusetts allows carriers to use tobacco as a rating factor; however, not one carrier currently applies it to policies sold in either the individual or small group markets. Massachusetts' health insurance market is not medically underwritten (i.e., modified community rating within a 2:1 age band).

Pros and Cons of Tobacco Ratings

The following pros and cons are summarized from David Dillon's "Report on Tobacco Rating Issues in Arkansas under the Affordable Care Act" and Rick Curtis and Ed Neuschler's report "Tobacco Rating Issues and Options for California under the ACA."

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.
- A substantial premium charge for tobacco use can encourage tobacco users to quit, and discourage others from starting. By quitting, these beneficiaries would improve their own 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.

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[6] Connecticut Health Insurance Exchange Joint Advisory Committee Meeting Review of (Revised) Staff Recommendation for QHP Certification Requirements November 2012. http://www.ct.gov/hix/lib/hix/11262012_Joint_AC_Meeting_Slides_(2).pdf

- 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, 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. Insurers might also use such a high tobacco-rating factor as an indirect way to charge more for people with expensive health conditions, given that those with mental disorders 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.

It should be noted that imposing a tobacco rating factor does add an administrative burden on carriers and employers to collect data for tobacco use in states that do not currently allow medical underwriting. However, the DC market is currently medically underwritten so this may not apply.