Tobacco Surcharges on Health Insurance Premiums and State Flexibility

ACS CAN places 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.
- A recent study of the impact in California concluded that "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 the ACA." (Curtis and Neuschler, 2012). Between 200,000 and 400,000 people would remain uninsured in California if the full tobacco surcharge is imposed.
- 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.
- Under the ACA, states have the option to use a rating lower than 1:5:1.

States should <u>not</u> apply the tobacco rating, or at least include policies that minimize negative impacts on tobacco users.

- States 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.
- States 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. States must close these gaps and eliminate discrepancies in benefits.
- States will see greater public health and economic benefits by raising tobacco excise taxes, implementing strong smoke-free laws, and funding prevention and cessation programs in their state than by raising insurance rates on tobacco users.