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The ACA's Tobacco Use Rating: Implementation, Inconsistencies and Ironies

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May 16, 2013

Guest Bloggers Professors Alice A. Noble and Mary Ann Chirba - The ACA's Tobacco Use Rating: Implementation, Inconsistencies and Ironies

As the Affordable Care Act continues toward full implementation, the law's complexity is on full display. As we have noted in earlier writings, the ACA continues the federal tradition of using a fragmented approach to allocating oversight responsibilities among federal and state regulators, while maintaining the role of private actors in health care insurance and delivery systems. The result is a dizzying array of plan types (self-insured, fully insured, small market, individual market, large market, grandfathered) subject to an equally dizzying blend of ACA, ERISA, and individual state requirements.

Time will tell if this uniquely American system will achieve the goals of reform, i.e., expanding access to care while improving its quality and controlling costs. Unexpected and unintended consequences, some fortunate and others not, will certainly flow from such a system. This post will consider the insurance market reforms, specifically, PHSA § 2701, "Fair Health Insurance Premiums," added by ACA § 1201 and some unexpected and seemingly unintended consequences related to the tobacco use rating provision.

Section 2701, which takes effect beginning in 2014, prohibits discriminatory premium rates by limiting the variables that insurers in the small group and individual market may use in setting premium rates. Prior to the ACA, insurers had greater latitude in setting premiums based on personal factors such as gender or health status. This often resulted in unaffordable insurance premiums for those most in need of health coverage: individuals with serious or chronic health conditions or small groups that included uch individuals. The ACA prohibits this type of underwriting in the small group and individual markets by permitting insurers to consider only four factors when setting premiums in these markets: 1) whether the coverage is for self-only or family enrollment; 2) the geographic area; 3) the age of the insured premiums may vary by a ratio of no more than 3:1 for adults); and 4) tobacco use (premiums may vary by a ratio of no more than 1.5:1).

Individuals who use tobacco may be required to pay up to 50% more for their health insurance premiums. For the sake of this provision, tobacco use is defined as using tobacco products on average of four or more times per week within no longer than the past six months, excluding religious or ceremonial uses of tobacco. Permitting a tobacco-use premium is consistent with the ACA's larger focus on individual responsibility: because tobacco use is voluntary and offers no health benefit, tobacco users should bear a significant portion of the higher health care costs associated with that activity. It is conceivable that over time, other voluntary activities, such as weight control, may be added to the list of permissible factors used to set premiums.

Like so many other aspects of the ACA, implementing the tobacco-use premium provision is anything but straightforward especially in light of highly fragmented health insurance markets. In addition to the type of plan or policy, grandfather status under the ACA, an insurer's ability to employ tobacco-use rating also depends on state law and the application of federal wellness programs regulations.

Several of the thornier aspects of this crazy quilt are especially deserving of attention, as follows:

1. Type of Insurance Coverage

The ACA's tobacco use rating provision does not apply to the following kinds of insurance plans:

- Self-insured employer-sponsored plans, whether large or small
- Grandfathered plans in all markets
- Insured plans in the large group market through 2016
- Insured plans in the large group market *after* 2016, but only if the state does not permit insurers to offer large group policies on the state's health insurance exchange

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These exceptions mean that, starting in 2014, and at least until 2017, the tobacco use premium applies *only* to individual and small group plans that are *both* insured and non-grandfathered, whether offered in or off state exchanges. As noted below, in 2017, upon the election of the state, large insurance issuers may also be subject to the provision.

2. State Laws

Recognizing that insurance regulation is traditionally a matter of state law, the ACA permits states some latitude in applying the tobacco-use premium. First, § 2701 does not preempt state insurance laws that prescribe a more consumer-friendly ratio than 1.5:1. Second, the state can prohibit the premium entirely without triggering federal preemption.

As noted, beginning in 2017, a state may elect to open its state health insurance exchange to large group insurers. Should a state choose to do so, § 2701's tobacco-use premium rating for the small group market will apply to all coverage offered in the (non-grandfathered) large group insurance market in that state.

A "subtheme" present here is that of fragmentation and multi-state employers. For those large employers offering employee health insurance coverage in more than one state, additional state-to-state variability will be introduced in 2017 when exchanges may be expanded to offer large group coverage Take, for example, the tobacco-use rating provision. Multi-state employers who purchase insurance coverage in the large group market will be required to take into account numerous factors for each state, such as: (1) Does the state permit large plans to participate in the exchanges, and, if so: (2) Does § 2701 tobacco-use rating apply as written, or does the state, as permitted, provide for a more consumer-friendly ratio, or even prohibit the application of tobacco-use rating. Under the ACA, the states continue to share authority for the regulation of health insurance with the federal government. This is nothing few--although the complexity of the regulations and the degree of fragmentation certainly is.

3. Small Group Markets

Beginning in 2014, those insured in the small group market are subject to the tobacco-use rate. The final implementing regulations promulgated by the Departments of Labor, Treasury, and HHS, however, significantly lessen the impact of this higher rate on the small group market by linking tobacco-use rating to the availability of a tobacco-related wellness program. The ACA encourages wellness programs as both a means of underscoring personal responsibility and as a strategy to reduce costs. This final health insurance market rule states that issuers are not permitted to impose the tobacco rating factor under § 2701 *unless it is imposed as part of a wellness program*.

Under this final rule, the tobacco-user rating may not be applied unless the tobacco user is afforded the opportunity to avoid paying the full amount of the tobacco-use rating factor by participating in a wellness program meeting the standards for wellness programs required by the ACA, found at PHSA § 2705(j). (The proposed wellness rule issued in November 2012 would increase the allowable reward percentage to 50% of the cost of employee-only coverage, bringing it in line with the cost of the tobacco-rating premium increase.)

Because PHSA § 2705(j) does not apply to the individual market, those with individual insurance coverage have no such opportunity to use their participation in a wellness plan to reduce the cost impact of a tobacco-use premium.

4. Individual Markets

It is perhaps in the individual markets where the ironies of the tobacco-use rating are most pronounced. As applied, the cost of § 2701's tobacco-use rating may prevent individuals who seek affordable coverage in the individual marketfrom obtaining it. Individuals who need a subsidy to purchase coverage through a state health insurance exchange will find that the subsidy may not be applied to that portion of the premium attributable to the tobacco-use rate. At up to 50 % of the cost of coverage, this is no small amount, especially for individuals already struggling to comply with the ACA's individual coverage mandate.

Insurance policies sold in the individual and small group markets must include coverage of certain preventative benefits with no cost sharing, including tobacco cessation treatment. Moreover, all policies in the individual and small group insurance markets must include essential health benefits, which also include coverage for preventive and wellness services. Ironically, however, individuals who cannot afford coverage due to the tobacco-use premium will not only lose coverage; they will also be denied
access to these tobacco-related treatment benefits that the ACA mandates for the small group and individual markets.

The plight of individuals who could not obtain coverage due to prohibitive costs and/or pre-existing health conditions was a driving force in getting health reform law through Congress. An equally powerful motivator was the need to control health care spending – especially when it came to wholly preventable costs. In its most recent fact sheet on smoking and tobacco use, the Centers for Disease Control and Prevention estimates that, for the period of 2000 through 2004, cigarette smoking generated some $193 billion per year in health-related economic costs with half of that amount devoted to direct medical expenses.[1] Such staggering amounts should come as no

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surprise. The American Cancer Society compares nicotine with cocaine and heroin because it is so highly addictive. In fact, nicotine is so efficient at inducing physical and psychological dependence that each year, 70% of smokers want to quit and 50% attempt to do so. Each year, however, only a paltry 4-7% manage to do so without the assistance of a tobacco-cessation program.[2]

Given the considerable costs that smoking generates for smokers and society in general, Congress's decision to permit insurers to consider tobacco use when determining premiums seems more than logical. In theory, a premium rating factor of up to 1.5:1 would make smokers financially responsible for at least a portion of these costs, thereby reducing the financial burden placed on the greater population. Simultaneously, the premium should incentivize tobacco users to give up the habit and, in the process, obviate the health problems and attendant costs of tobacco use.

Underscoring the need for individuals to take responsibility for their actions is fully consistent with the CA's overall goals. However, the tobacco-use rating provision should not be implemented in a way that undermines its objectives. Without change, however, the planned implementation of § 2701 will do just that. Allowing the tobacco-use premium to deprive smokers in the individual market access to affordable coverage and tobacco cessation programs will only exacerbate the problems it is designed to prevent.

Despite the reality of fragmented markets, for § 2701 to accomplish its essential goals of reducing tobacco use, allocating costs more fairly and reducing overall health care spending, it must be nterpreted and applied in a more rational and consistent manner.

Alice A. Noble and Mary Ann Chirba

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[1] http://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/

[2] http://www.cancer.org/cancer/cancercauses/tobaccocancer/questionsaboutsmokin about-smoking-tobacco-and-health-is-tobacco-addictive

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