IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 65958, Washington, DC 20036-5303
Telephone (580) 924-8280 Ext. 4122 ~ Facsimile (580) 920-3138 ~ Website: www.tribalselfgov.org

Sent Via Email: Rene.Joseph@ihs.gov
Geoffrey.Roth@ihs.gov
Original Sent Via USPS

August 23, 2013

Dr. Yvette Roubideaux, M.D., M.P.H. Director
Attn: Geoff Roth, Special Assistant to the Director
Indian Health Service
Suite 440, The Reyes Building
801 Thompson Avenue
Rockville, MD 20852-1627

RE: Transmittal of TSGAC Final Report, "Tobacco Issues for American Indians and Alaska Natives in the Patient Protection and Affordable Care Act (P.L. 111-148)"

Dear Dr. Roubideaux:

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), we are pleased to submit the following report entitled, "Tobacco Issues for American Indians and Alaska Natives in the Patient Protection and Affordable Care Act (P.L. 111-148)." This report has been prepared as part of the deliverables identified under the health care reform implementation funding provided by the Office of Tribal Self-Governance (OTSG) to the TSGAC.

This Report provides a summary, overview and recommendations for Tribes to consider regarding the possibility of higher premium prices due to the tobacco surcharge, and to contemplate policies regarding people who smoke. We would like to thank you and other key IHS senior officials for your on-going support and funding of this important and critical work. Reports such as this will greatly assist to advance our efforts in health care reform implementation.

Transmittal letters and original copies of the Report are also being sent to the Director, Office of Tribal Self-Governance (OTSG) and Director, Office of Resource Access and Partnership (ORAP). Should you need additional information or have questions regarding the report, please contact me at (860) 862-6192; or via email: lmalerba@moheganmail.com. Thank you.

Sincerely,

Lynn Malerba

Chief Lynn Malerba, Mohegan Tribe
Chairwoman, TSGAC

cc: P. Benjamin Smith, Director, OTSG, IHS
Carl Harper, Director, ORAP, IHS
TSGAC and Technical Workgroup

Enclosure (1) *Report - Tobacco Issues for American Indians and Alaska Natives in the Patient Protection and Affordable Care Act (P.L. 111-148)*

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c/o Self-Governance Communication and Education
P.O. Box 65958, Washington, DC 20036-5303
Telephone (580) 924-8280 Ext. 4122 ~ Facsimile (580) 920-3138 ~ Website: www.tribalselfgov.org

Sent Via Email: Benjamin.Smith@ihs.gov
Original Sent Via USPS

August 23, 2013

Mr. P. Benjamin Smith, Director
Office of Tribal Self-Governance
Indian Health Service
Department of Health and Human Services
Suite 240, The Reyes Building
801 Thompson Avenue
Rockville, MD 20852-1627

RE: Transmittal of TSGAC Final Report, "Tobacco Issues for American Indians and Alaska Natives in the Patient Protection and Affordable Care Act (P.L. 111-148)"

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P.O. Box 65958, Washington, DC 20036-5303
Telephone (580) 924-8280 Ext. 4122 ~ Facsimile (580) 920-3138 ~ Website: www.tribalselfgov.org

Sent Via Email: Carl.Harper@ihs.gov
Original Sent Via USPS

August 23, 2013

Mr. Carl Harper, Director
Office of Resource Access and Partnership
12300 Twinbrook Pkwy. Suite 360
Rockville, MD 20852-1627

RE: Transmittal of TSGAC Final Report, "Tobacco Issues for American Indians and Alaska Natives in the Patient Protection and Affordable Care Act (P.L. 111-148)"

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P. Benjamin Smith, Director, OTSG, IHS
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Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Tobacco Issues for American Indians and Alaska Natives In The Patient Protection and Affordable Care Act, P.L. 111-184

Report Prepared by:
Tribal Self-Governance Advisory Committee (TSGAC)

August 23, 2013

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Tyson Johnston, Council Member
Quinault Indian Nation

Richard Narcia, President
Gila River Health Care Corporation

Acknowledgements:
Thank you to Indian Health Service for providing funding for this report.

Report Researched by:
Mim Dixon, Health Care Consultant, TSGAC

For more information, please contact:
Self-Governance Communication and Education Tribal Consortium
P.O. Box 65958, Washington, DC 20036-5303
Telephone (580) 924-8280 Ext. 4122 ~ Facsimile (580) 920-3138 ~ Website:
www.Tribalselfgov.org

Table of Contents

Summary of Key Points

- Starting October 1, 2014, as many as 29 of the 35 States with Tribes could have tobacco surcharges on plans offered in State Marketplaces and the Federally-facilitated Marketplace (FFM). Only 6 States and the District of Columbia have eliminated the tobacco rating.

- The Patient Protection and Affordable Care Act (ACA) prohibits insurers from charging more for health insurance based on health status or pre-existing conditions; however, it does allow insurance companies to increase premiums by as much as 50 percent for people who use tobacco (called a surcharge or tobacco rating). The tobacco surcharge is not covered by federal tax credits for insurance premiums, and this can make insurance unaffordable for people who smoke. For example, a person at 150 percent of the federal poverty level (FPL) could pay 500 percent more for premiums if they smoke compared to a non-smoker at the same FPL.

- The tobacco surcharge on health insurance premiums does not apply to religious or ceremonial use of tobacco. However, it affects American Indian/Alaska Native (AI/ANs) access to insurance more than other groups because AI/ANs have a higher rate of smoking (31 percent of AI/AN adults compared to 19 percent for the U.S. average). The tobacco rating creates a way for insurance companies to avoid risk by increasing the costs of premiums for people who smoke and making it unaffordable for them to purchase insurance and become part of the risk pool.

- The tobacco surcharge could make Tribal Sponsorship much more expensive, and it is may not be factored into existing Tribal Sponsorship models. Tribes should consider the tobacco surcharge in their Tribal Sponsorship analysis, policies and selection of insurance plans.

- States can prohibit tobacco surcharges on insurance premiums or limit the tobacco rating below the 50 percent allowed in ACA. States have this authority in both State Exchanges, the Federally-Facilitated Exchange or Marketplace (FFE/FFM), and plans offered outside Exchanges.

- Groups such as the American Cancer Society, the American Lung Association, and Families USA are opposed to tobacco rating because it is not effective at motivating people to quit smoking, it hurts people who tend to be uneducated and poor, and it makes insurance unaffordable for some persons who need it most.

- Tribes and Tribal Organizations within States that have not already prohibited or limited the tobacco surcharge need to work with allies in the State and with the State Insurance Commissioner and legislators to prohibit or limit tobacco ratings at the state level, regardless of whether their State will be served by a State Exchange or an FFM.

Introduction

There are no Indian-specific rules about tobacco in the ACA, and religious and ceremonial uses of tobacco are protected. However, the rules permitting a tobacco surcharge will affect the cost of Tribal Sponsorship and will likely leave many people who smoke uninsured. This is a particular problem for AI/ANs because nearly one-third of adults are smokers, more than any other group in America.

There are two different types of tobacco provisions in the ACA. One creates the option for large employers to reduce employee contributions to health insurance premiums if they are non-smokers or enrolled in a smoking cessation program. The other provision permits insurance companies to vary premiums by adding as much as a 50 percent surcharge for tobacco users, unless a State prohibits or further restricts tobacco ratings.

People who do not have employer-sponsored insurance and want to purchase insurance on an Exchange may find that the tobacco surcharge makes the insurance unaffordable as the ACA's premium tax credits do not cover the tobacco surcharge. The tobacco surcharge may also have a significant effect on the cost of Tribal Sponsorship for people who smoke.

In both of the rules, there are opportunities for employers and insurance companies to reduce their costs by excluding smokers from the insurance pool. Tribes have been concerned about insurance companies engaging in risk avoidance to exclude AI/ANs, and it appears that this is a legal route for insurance companies to do so. However, States have the power to prohibit or limit tobacco rating below the level allowed by the ACA.

Definition of Tobacco Use and Identification of Tobacco Users

The definition of tobacco use for purposes of authorizing a premium surcharge is provided in 45 CFR 147.102(a)(1)(iv), as follows:

> *For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.*

The definition of tobacco use excludes American Indian or Alaska Native ceremonial or religious use of tobacco. However, it does include all other types of tobacco use. It is not clear how insurers will know if someone is a tobacco user. Newspaper reports say it will be an "honor system" with people acknowledging that they are smokers.[1]

[1] Michelle Andrews, *Washington Post*, July 16, 2013, "Smokers will pay more in some States, but not in DC."

However, there are no questions about individual tobacco use in the three simplified paper applications that were released by CMS, and the computer application has not yet been released. It appears that the application process has two steps. Exchange eligibility and financial assistance is determined in the first step, which is the only part covered in the paper applications. In the second step, plan selection is made and this is where the question on tobacco use is likely to be. When people compare premiums in a metallic level, the variation in price might be due to a tobacco surcharge for those insurers who decide to include this in their premium.

According to CMS rules, if a person lies about tobacco use, they will have to pay the surcharge amounts that should have been paid in the current coverage year, but the insurer cannot exclude the person from coverage or require payment for prior years.

Large Employer Wellness Programs

New rules state that large employers cannot be subject to charges of discrimination if they create incentives for employees to participate in wellness programs.[2] The rules, which apply to both insured and self-insured plans, can be used by employers to vary premiums, co-pays, deductibles, and co-insurance for individuals who adhere to health promotion and disease prevention programs, including smoking cessation programs.

The penalty for tobacco use is much higher than for other health risks. Employers can vary premiums contributions by as much as 50 percent for smokers, but only up to 30 percent for other risks, such as being overweight or having high cholesterol or high blood pressure.[3]

In essence, it means that smokers could pay more for employer-sponsored insurance than non-smokers. However, if smokers enroll in a smoking cessation program, then they would pay the same as non-smokers.

Some employers are very enthusiastic about this concept because they believe it will reduce health care costs and improve absenteeism. However, recent research mandated by Congress as part of ACA that was conducted by RAND with 600 employers indicates that outcomes from the employer wellness programs do not reduce health care costs.[4]

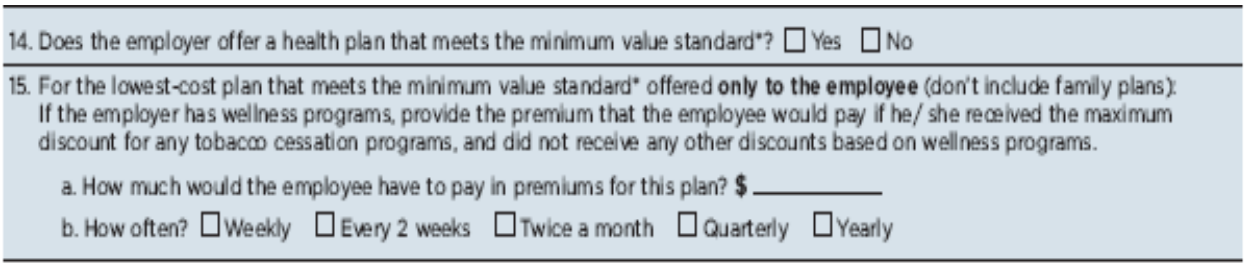
[2] Final Rule on Incentives for Nondiscriminatory Wellness Programs in Group Health Plans was issued in 2013 by Department of Treasury, IRS (26CFR Part 54), the Department of Labor, Employee Benefits Security Administration (29 CFR Part 2590), and the Department of Health and Human Services (45 CFR Parts 146 and 147).

[4] Results of the study have been reported, but the study has not yet been released for publication.

When employers offer smoking cessation programs, the rules that relate to affordability of insurance for purposes of qualifying for tax credits in the Exchange are different from the rules that relate to eligibility for the affordability hardship exemption.

Premium Tax Credits in Exchanges. For employed individuals to qualify for federal tax credits in the Exchange, they must show that their employer's health insurance, if offered, is not affordable. Even if employers charge higher premiums for smokers, the rules say that the premiums for non-smokers are to be used to calculate affordability of insurance, if the employer offers smoking cessation programs.

There are three types of paper applications for Exchanges. For the long form, called "Application for Health Coverage & Help Paying Costs," there is Attachment A which includes question 15 on employer coverage regarding tobacco:



14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

The same questions are on both the page that the employee fills out and the page that the employer fills out.

By using the "premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs," the calculation of affordability is not based on the actual premium that a smoker would have to pay. This means that employers who offer smoking cessation programs are not penalized if they make insurance unaffordable for smokers. At the same time, it means that smokers who have access to employer-sponsored smoking cessation programs do not qualify for tax credits on the Exchange even if their *actual* premium costs exceed the 9.5 percent "affordability" threshold. Smokers who do not enroll in smoking cessation programs could be blocked from accessing tax credits in the Exchange because their employer-sponsored insurance is considered affordable using the premium costs the employees would have if they had enrolled in a smoking cessation program offered by their employer.

Hardship exemption for smokers. People who smoke may be unable to receive premium tax credits through an Exchange because affordability of employer-sponsored insurance is based on non-smoker premiums; however, people who smoke are likely to receive an affordability hardship exemption, which means they would not have the pay the individual mandate (or tax penalty). This is because the hardship exemption considers the actual premium that a smoker would have to pay, instead of the non-smoker premium. As a result, people who smoke could end up uninsured, even though

they tend to be the very people ACA intended to help – predominantly low educated, low income people with poor health. [5]

For AI/ANs, access to the hardship exemption based on unaffordability due to the tobacco rating is not very important since they would qualify for one or two other exemptions from the individual mandate: (1) the Indian exemption for those who qualify under the ACA definition of Indian (enrolled Tribal member or shareholder in an Alaska Native village or regional corporation); and, (2) a hardship exemption for those who qualify as AI/AN under the Medicaid rules (includes all Indian Health Service, Tribal and Urban (I/T/U) users and others).

Tobacco Surcharge in Individual Exchanges and SHOPS

While the ACA prohibits insurance companies from discriminating against people with pre-existing conditions, the only exception is tobacco use. Insurance companies are allowed to use a "tobacco rating," which means that they can charge more for premiums for people who are tobacco users. Furthermore, insurance companies can vary the tobacco surcharge by age. The federal law allows insurance companies to charge up to 50 percent more for premiums for people who use tobacco. If States prohibit tobacco rating or restrict tobacco rating to a lower percentage, then the State law or regulation applies. In other words, the ACA considers this a matter for State insurance regulation and the 50 percent limit only applies if States have not set a lower limit.

When the State allows tobacco rating in insurance premiums, it does not necessarily mean that insurance companies will institute a tobacco surcharge. For example, when Massachusetts started its health insurance exchange, it allowed tobacco rating but no insurance companies adopted the practice.

For the individual Exchange, it is a "catch 22" because the Exchange plans must provide smoking cessation programs and related medications as part of the essential health benefits (EHBs), but it is possible that the premiums will be too high for smokers to enroll in the Exchange plans and take advantage of the programs. If the premiums become unaffordable, individuals can apply for a hardship exemption from the individual mandate (tax penalty).

Calculating Tobacco Surcharge and Premium Tax Credits

The premium surcharge is applied to each person in the family who may legally use tobacco under federal and State law. Thus, it would not be applied to children who smoke. Federal tax credits to offset the costs of premiums for people below 400 percent of the poverty level do not apply to the tobacco surcharge.

The following example illustrates the impact of the surcharge[6]:

[5] http://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-States on 6/30/13.

An individual with an income of $17,235 (150% FPL) is expected to pay not more than 4 percent of his/her income for health insurance. If the second lowest cost silver plan premium is $449 per month for a person who doesn't use tobacco, then the federal tax credit would pay $392 per month and the individual would pay $57 per month.

However, if the individual is a smoker, his/her monthly premium could go up by 50 percent to $673.50. The federal subsidy would remain at $392 per month and the individual would have to pay $281.50 per month. This is an increase to the individual of nearly 500 percent (5 times higher) instead of 50 percent greater. The individual would end up paying $3,378 per year which is 20 percent of their income. In this case, insurance would be deemed unaffordable, and they could get an exemption from the tax penalty if they chose not to purchase insurance.

The comparison in costs between a person at 150 percent FPL who smokes and a non-smoker in the above example is shown in the following chart:

Comparison of Premiums for Non-smokers and Smokers at 150 percent FPL

	Non-smoker	**Smoker**
Annual income	$17, 235	$17, 235
2nd lowest cost silver plan premium	$449/mo	
Individual contribution (4% of income =$57/mo)	$57/mo	
APTC at 150% FPL	$392/mo	$392/mo
Premium with 50% tobacco surcharge for smokers		$673.50/mo
Individual contribution to premium	$57/mo	$281.50/mo
Annual cost to individual (or Tribal Sponsorship)	$684/yr	$3,378/yr
Individual contribution to premium as percent of income	4%	20% (qualifies for hardship exemption

Source: Families USA Fact Sheet, "Tobacco Rating: Issues for Consumers," May 2013.

In the above example, if a Tribe were considering sponsoring an individual who does not meet the ACA definition of Indian (and therefore cannot apply the Advance Premium Tax Credit, or APTC, to a bronze plan), the cost to the Tribe for the unsubsidized portion of the premium would be $3,378 per year, compared to $684 for a similar person who is a non-smoker. Many if not all of the the Tribal Sponsorship models that have been developed to date have not considered the tobacco surcharge in the costs. The models have been based on the individual premium contribution percentages of income, and not on the actual plan premiums, which have been unknown. The models have used the limits on individual contributions to calculate the cost of Tribal Sponsorship, wrongly assuming that the tax credits would be increased to cover the total premium cost, inclusive of any tobacco surcharge.

[6] Based on example in Families USA Fact Sheet, "Tobacco Rating: Issues for Consumers," May 2013.

The cost of the tobacco surcharge may be greater for older people, because they already face higher premiums and the surcharge is based on those premiums. The tobacco surcharge also affects people at lower income levels more than at higher income levels when considering the percentage of income required to obtain health insurance, and because people who are at lower income levels and with lower educational levels are more likely to be smokers.[7]

To compound this disparity, the Federal government is increasingly concerned about enrolling young adults in the FFE/FFM to keep the cost of insurance lower for everyone, so they may be encouraging lower tobacco surcharges for young people. Insurers have lower costs for younger smokers than for older smokers, so they also may have incentives to make the surcharge different for younger people than older people, and the HHS rules allow a health plan to set different surcharge percentages for different age groups.

Greater Impact of Surcharge on American Indians and Alaska Natives

The Centers for Disease Control and Prevention (CDC) published 2011 data indicating that the smoking rate among AI/AN adults is 31.5 percent, which is higher than any other ethnic group considered in their report.[8] By comparison, smoking rates among adults who are non-Hispanic Whites is 20.6 percent, Blacks 19.4 percent, Hispanics 12.9 percent, and Asians 9.9 percent. On average, 19 percent of adults in the United States smoke, making AI/AN smoking rates 50 percent greater than the national average. IHS has long noted that smoking rates vary from Area to Area.

The tobacco surcharge can become a mechanism for insurance company risk avoidance.[9] AI/AN advocates have been concerned about risk avoidance practices by insurance companies that would limit access to Marketplace plans for AI/ANs, and it appears that this is one policy that would affect AI/AN disproportionately. However, those who qualify for the zero cost sharing plans and limited cost sharing plans can use their APTC for bronze plans and this may save enough money to offset the tobacco surcharge under the silver plans.

Delayed Implementation of Tobacco Surcharge in the FFE/FFM

On June 28, 2013, CMS issued a document called, "QHP Webinar Series Frequently Asked Questions," which explained that full implementation of the tobacco rating would be delayed until after calendar year 2014. The following is the full question and answer:

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[7] http://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-States on 6/30/13.
[8] http://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-States on 6/30/13.
[9] David M. Dillon, Lewis and Ellis, Inc – Actuaries & Consultants, "Report on Tobacco Rating Issues in Arkansas under the Affordable Care Act, February 2013.

Q67: The regulations allow for a 1.5:1 rate factor for tobacco use. However, the Rate Template does not allow for this and errors out because the spread in some instances is more than 3:1 by age. For example, take a 21 year old smoker and a 64 year old smoker. [Y]ou might have a 1.10 smoking factor for the 21 year old and a 1.30 factor for the 64 year old smoker. When you apply the age factors, the 64 year old smoker would have a rate that is more than 3 times higher than the 21 year old smoker. Will there be an opportunity to updates the rates issuers submitted during the application window?

A67: The preamble to the Health Insurance Market Rules Rate Review final rule (Market Rule) published on February 27, 2013, States that younger enrollees could be charged a lower tobacco use factor than older enrollees provided the tobacco use factor does not exceed 1.5:1 for any age group. For example, a 21-year-old smoker could be rated at 1.2 to 1 and a 65-year-old smoker can be rated in the same plan at 1.5 to 1. Because of a system limitation in the Rating Tables Template, however, the system currently cannot process a premium for a 65-year-old smoker that is rated more than 3 times the premium of a 21-year-old smoker. Accordingly, HHS asks that, until further notice, all issuers that are required to use the Rating Tables Template and that will be offering non-grandfathered plans in the individual and small group markets implement the tobacco rating factor for their non-grandfathered policies so that older adult smokers are not rated in total more than 3 times of the total rate for a younger adult smoker. One way to accomplish this is if an issuer imposes a 1.2 to 1 tobacco rating factor on a 21-year -old smoker, the issuer should use the same 1.2 tobacco rating factor for the 65-year-old smoker. If an issuer implements the tobacco rating factor with the result that an older smoker is rated up more than 3 times of that of a younger smoker, the submission of the issuer will be rejected by the system. HHS intends to implement a system change that will allow for processing of tobacco rating factors that vary based on age, and HHS expects this to be completed after calendar year 2014. HHS also reminds issuers that the Market Rule provides that a tobacco rating factor may be applied only with respect to individuals who may legally use tobacco under federal and state law. Different States may have different age limits regarding the sale of cigarettes. If a state, for example, prohibits the sale of cigarettes to individuals under the age of 19, then individuals under the age of 19 in that state cannot be rated for tobacco use. Therefore, health insurance issuers seeking to impose tobacco rating should be aware of the age limit

in every state where they will offer health insurance coverage subject to tobacco premium rating.

In summary, for the first year (2014) the tobacco surcharge will only be partially implemented in the FFM. This makes the impact of the tobacco rating less at the start-up of the FFM and gives Tribes and Tribal Organizations time to work at the State level to prohibit or limit tobacco ratings in future years.

Even with the reduction in the tobacco surcharge in the first year, and the ability for people who meet the definition of Indian to apply the APTC to a bronze plan, the impact on Tribal Sponsorship may be considerable, as the following example illustrates.

The following table compares premiums for a non-smoker and a smoker who is 60 years living in the Farmington area of New Mexico and earning 350% FPL. In the actual plans offered, the lowest cost bronze plan has no tobacco rating, so for purposes of this example, we use the second lowest cost bronze plan for both nonsmoker and smoker.

Comparison of Premiums for 60-year-old Non-smoker and Smoker at 350% FPL, New Mexico, Farmington Area, for 2014[10]

	Non-smoker	**Smoker**
Annual income	$40,215	$40,215
2nd lowest cost silver plan premium	$555.48/mo	
APTC at 350% FPL (9% of income=$301.61/mo)	$253.87/mo	$253.87/mo
Bronze plan premium	$455.82/mo	$554.25/mo
Individual contribution to premium	$201.95/mo	$300.38/mo
Annual cost to individual (or Tribal Sponsorship)	$2,423.40yr	$3,604.56/yr

Source: Families USA Fact Sheet, "Tobacco Rating: Issues for Consumers," May 2013. Adapted using rates published for New Mexico.

The above example illustrates that the annual cost of Tribal Sponsorship is $1,181 more for a smoker than a non-smoker for 2014, and that is a 49 percent increase in annual premium costs.

Tribal Sponsorship Considerations

Tribes have a number of ways to address the tobacco rating in their Tribal Sponsorship programs if their State does not prohibit the tobacco surcharge on premiums.

Cost/benefit analysis of Tribal Sponsorship. If Tribes choose to cover everyone, then they should factor into their economic models a higher premium for smokers. They may not be able to do this until their Marketplace publishes plan premiums. Because

[10] Based on New Mexico rates published at https://www.statereforum.org/sites/default/files/printformat_nmhi_2014.pdf on August 1, 2013.

smoking rates vary from Area to Area, the Tribe should try to use a Tribal-specific or Area-specific smoking rate in their calculations. If these local smoking rates are not available, then they could use the national average that 30 percent of AI/AN adults smoke.

Until premiums are published, Tribes have been unable to calculate the savings from applying the APTC to bronze plans. The lower cost of bronze plan premiums can negate the tobacco surcharge for people at lower income levels, particularly if they are in a lower age bracket.

The following example is based on the New Mexico premium rates[11] published on the Refor(u)m website.[12] The second lowest cost silver plan monthly premium for a 50-year-old nonsmoker living in a rural area is $404.45, for an HMO offered by Molina Health Care of New Mexico. The lowest cost bronze plan monthly premium for a 50-year-old non-smoker living in a rural area is $275.77, while for people who smoke it is $303.35. In both cases, the bronze premium is lower than the APTC, so there is no cost to the individual or for Tribal Sponsorship.

Comparison of Premiums for 50-year-old Non-smoker and Smoker at 150 percent FPL, New Mexico, Rural Area, for 2014

	Non-smoker	**Smoker**
Annual income	$17, 235	$17, 235
2nd lowest cost silver plan premium	$404.45/mo	
APTC at 150% FPL	$347.35/mo	$347.35/mo
Lowest cost bronze plan premium	$275.77/mo	$303.35/mo
Individual contribution to premium	$0/mo	$0/mo
Annual cost to individual (or Tribal Sponsorship)	$0yr	$0/yr

Selection of Plans for Tribal Sponsorship. Even when tobacco rating is not prohibited or limited by the State, some insurance companies may choose not to use tobacco ratings in their premiums for Exchange plans. Tribes could avoid the additional cost of Tribal Sponsorship due to tobacco rating by choosing plans that do not have tobacco rating, if they are available.

Tribal Smoking Cessation Programs. Tribes could step up their smoking cessation programs by offering them more frequently and creating incentives for people to enroll. Also, they can find ways to reduce recidivism in the first six months after people participate in smoking cessation programs. After six months, people would be eligible for insurance on the Exchange without the tobacco surcharge.

[11] New Mexico's premium rates are given for four geographic areas or zones: 1) Albuquerque MSA, 2) Farmington, MSA; 3) Las Cruces, MSA; 4) Santa Fe, MSA; and 5) Rural, MSA, which is all the counties throughout the state not included in the other four metropolitan statistical areas.

[12] https://www.statereforum.org/sites/default/files/printformat_nmhi_2014.pdf on August 1, 2013.

Policies for Tribal Sponsorship. Tribes could control their costs of their Tribal Sponsorship program by adopting policies, such as the following:

- Choose not to sponsor people who smoke if their premium exceeds a specified amount.

- Offer Tribal Sponsorship to everyone, both smokers and non-smokers. Encourage smokers who are sponsored to attend smoking cessation program events, and bill the insurance company for both counseling services and medications that help with smoking cessation. Track the progress of people who are quitting smoking and change their enrollment to a plan without the tobacco surcharge after they have been smoke-free for 6 months. If they have not quit smoking within one year, and the costs of premiums exceeds the benefits, do not sponsor smokers for a second year.

- Consider smokers on a case-by-case basis to determine whether the cost of premiums would be offset by revenues and savings in Contract Health Services (CHS), particularly for people who have high cost health needs.

- Require people who smoke to share in the excess cost of their premiums through reductions of their per capita payments, performance of community service, or other means.

If Tribal Sponsorship does not cover people who smoke, their services from the I/T/U would not change.

State Options to Limit or Prohibit the Tobacco Surcharge

States can limit or prohibit the tobacco surcharge. State rules restricting the tobacco surcharge would apply to plans offered both inside and outside the Exchange, regardless of whether the Exchange is operated by the State or the Federal government. Six States (California, Massachusetts, New Jersey, New York, Rhode Island and Vermont) and the District of Columbia prohibit tobacco ratings.[13] However, 44 States allow insurance companies to use tobacco ratings.

While ACA limits insurance companies to the maximum of a 50 percent surcharge on premiums for tobacco use, the following States have set lower limits for surcharges[14]:

Arkansas	20 percent
Colorado	15 percent
Connecticut	5 percent
Kentucky	40 percent

[13] Market Rating Reforms (updated June 4, 2014), www.CMS.gov/CCIIO, July 23, 2013.
[14] Market Rating Reforms(updated June 4, 2013), www.CMS.gov/CCIIO, July 23, 2013.

As States consider their options, many are referring to a report by David M. Dillon for the State of Arkansas.[15] Dillon's review of the literature suggests that the actual additional costs of medical care for smokers is in the range of 30-35 percent for people who are under 65 years old, so the 50 percent surcharge is not justified actuarially.

Dillon analyzes the tradeoffs of various approaches to reduce the maximum allowable surcharge below the 50 percent allowed in ACA, using the following options:

- Apply the ACA 50 percent tobacco use surcharge to the subsidized premium amount
- Apply a 20 percent tobacco use surcharge to the total premium amount
- Apply the 20 percent tobacco use surcharge to the subsidized premium amount
- Apply a 10 percent tobacco use surcharge to the total premium amount
- Apply the 10 percent tobacco surcharge to the subsidized premium amount
- Apply a tobacco use surcharge that increases with age

State policies restricting the use of tobacco rating are generally made by the Office of the Insurance Commissioner, and they apply to all health insurance policies offered in the state. It is not clear that the federal directive for State Exchanges and Medicaid and CHIP programs to consult with Tribes extends to Health Insurance Commissioners. However, some States have their own Tribal consultation policies, and these could be invoked to engage in discussions about the impact of the tobacco surcharge on access to care.

Tribal Consultation and Advocacy

At the State and national level, there is advocacy to restrict or prohibit the tobacco surcharge from a wide range of stakeholders. Organizations such as Families USA, the American Lung Association and the American Cancer Society oppose the tobacco surcharges. Among the American Lung Association talking points are the following[16]:

- Punitive measures like tobacco surcharges have not been proven effective in encouraging smokers to quit and reducing tobacco use.
- There are plenty of other policies that <u>are</u> proven to reduce tobacco use: like increasing tobacco taxes, enacting smoke-free laws, funding tobacco control programs, and making tobacco cessation treatment accessible though health insurance coverage and quit lines.

[15] David M. Dillon, Lewis and Ellis, Inc – Actuaries & Consultants, "Report on Tobacco Rating Issues in Arkansas under the Affordable Care Act, February 2013.
[16] American Lung Association, "Tobacco Surcharges."

Tribes also need to advocate for a prohibition of the tobacco surcharge on the basis that it affects AI/AN disproportionately and it will make Tribal Sponsorship programs more expensive, thereby inhibiting access to health insurance.

To some extent, this appears to be another "red state versus blue state" issue. States with Republican governors who are committed to seeing Obamacare fail, may find strategic value in tobacco ratings that make insurance unaffordable, as well as seeing the tobacco surcharge as the way to institute personal responsibility for health care costs.

Recommendations

1. As Tribes consider Tribal Sponsorship programs, they must factor in the possibility of higher premium prices due to the tobacco surcharge, and consider policies regarding people who smoke.

2. Tribes should work in cooperation with allies within their States to prohibit the tobacco surcharge, because it affects AI/AN disproportionately and it makes premiums more expensive for Tribal Sponsorship programs.

3. Efforts by national Indian organizations to educate the National Association of Insurance Commissioners (NAIC) should include a discussion of the impacts of tobacco rating on AI/AN access to health insurance.