



ACTION ON SMOKING AND HEALTH
2013 H Street NW • Washington DC 20006-4207 • (202) 659-4310
<http://ash.org>

A Proposal to Help Fund Health Care Reform AND Reduce Its Huge Costs by Incorporating Personal Responsibility for Expensive Lifestyle Choices

Action on Smoking and Health (ASH), America's first antismoking organization, respectfully proposes an amendment, recently featured in a report on *MSNBC*, to pending health care reform legislation which would accomplish several major goals:

1. Meaningfully **incorporate "personal responsibility"** into health care reform, rather than just talking about it
2. **Provide tens of billions of dollars in much needed revenue** for health care reform without any new taxes
3. Substantially **reduce overall health care costs quickly** by slashing the number of medical problems which have to be treated, rather than simply tinkering around the edges of the system by trying to reduce the costs of treating very expensive diseases and medical problems such as heart attacks, strokes, lung- and other cancers, etc.

SUMMARY OF PROPOSED AMENDMENT

In summary, **ASH** proposes adding (rather than simply talking about) "personal responsibility" to health care by requiring smokers to pay a surcharge (in the nature of a user fee) on health insurance premiums, with the revenue being used to support health care reform generally, and with a small portion dedicated to antismoking efforts.

This health care reform legislative proposal was recently featured in a report on *MSNBC* entitled: "**HEALTH REFORM IDEA . . . Critics Say Consequences of Individual Choice Missing from Reform Debate**":
http://www.msnbc.msn.com/id/32306655/ns/health-health_care/

Since **smokers cost the American public about \$200 billion a year** in excess and unnecessary health care costs and other expenses, requiring them to pay even a small portion of that -- much less to shoulder their fair share of these enormous costs -- would **raise new revenue at least comparable to that of the major proposals** for funding health care, but would do so without any new taxes, and without imposing additional burdens on taxpayers who are in no way responsible for bloated health care expenses.

Moreover, since it is well established that anything which increases the cost of smoking -- e.g., higher cigarette taxes, increases in prices by manufacturers or sellers, etc. -- substantially reduces consumption and strongly encourages quitting, even a moderate surcharge **would significantly reduce the overall costs of health care** by slashing the number of heart attacks, cancers, strokes, etc., rather than simply tinkering around the margins by reducing the costs of treating these expensive diseases.

Thus **ASH** proposes a **surcharge (user fee)** of X% or \$Y (a legislative choice) on any **premiums paid by a smoker for health insurance**, with the revenue going to the government for health care reform generally, but also with a tiny portion to be used for antismoking and smoking cessation activities.

LIMITATIONS OF SENATOR GREGG'S WELLNESS AMENDMENT

A wellness amendment to a pending health care reform bill, offered by **Senator Gregg** (and apparently accepted in the draft) would, as we understand it, simply permit health insurance companies to provide a nonsmoker discount. But the federal government has permitted that at least 1986.

It also ruled in 2004, in response to a legal proposal from ASH, that, despite **HIPPA**, health insurance companies can continue to do so -- since **smoking is classified as a "behavior"** rather than as a disease or a "health status" (a classification which would both limit and restrict any such differential health insurance premiums). SEE: <http://ash.org/higher4smokers>

Despite this freedom, which the Gregg amendment apparently does not expand or otherwise even change, most health insurance companies charge smokers and nonsmokers the same rates, **effectively forcing the great majority of nonsmokers to pay the costs imposed on the overall program by smokers.**

Thus there is no reason to believe that -- given no additional mandate or even more incentive from the Gregg amendment or any other portion of the proposed legislation -- any significant number of health insurance companies will begin offering nonsmoker discounts.

Even if they did, such a move would provide none of the additional revenue so badly needed to help fund overall health care reform. Any such savings -- including the lower premiums and/or the lower costs of treating former smokers -- would go either to the policy holders or (far more likely) to the insurance companies. ASH suggests that **this money could better go to help fund health care reform.**

ADVANTAGES OF ASH'S PROPOSED AMENDMENT

Since the user fee on smokers would be uniform, there would be a level playing field, and health insurance companies would not have to worry about angering existing or potential customers who might be smokers, or mounting campaigns to justify or explain the difference in insurance costs.

Because increasing cigarette taxes, even by huge amounts, has proven to be enormously popular with voters -- since the taxes bring in additional revenue while also reducing smoking and related health costs -- there is every reason to believe that a smoker surcharge would also enjoy widespread voter support, especially compared with other funding proposals which involve new taxes, do nothing to lower health care expenses, and are not targeted to those who inflate those costs.

Indeed, *MSNBC* has just reported that, unlike most health-reform funding proposals, **charging smokers more for health insurance is backed by a majority of voters.**

http://www.msnbc.msn.com/id/32306655/ns/health-health_care/

This is especially true since it would be seen more as a user fee than as a tax since the added charge is only a **small percentage of the huge costs smokers themselves now impose on the health care system** and ultimately on nonsmokers, because the revenue would be used to help fund the very popular goals of expanding health insurance coverage and health care reform, and because any person can avoid the charge simply by quitting smoking.

Such a smoker surcharge would be consistent with **President Obama's** recent remarks: e.g., *"we've got to have the American people doing something about their own [health] care."* It would also put into practice the policy of **HHS Secretary Kathleen Sebelius**: *"personal responsibility extends to lifestyle; that in order to have a healthier America, a more productive America, we need to make some basic changes . . ."*

Many current and former Members of Congress, as well as numerous commentators and organizations, have all stressed the need for **"personal responsibility" as a cornerstone principle of health care reform**, yet this smoker-surcharge proposal is the first one to put the pontification into practice. **If adults should have the choice whether or not to smoke, it's high time they be required to accept at least some personal responsibility** for the financial and other consequences of their choice to others.

COMPARISON WITH OTHER FUNDING PROPOSALS

America's approximately **46 million smokers already spend over \$90 billion annually** on tobacco products, and their choice to use such products **adds almost \$200 billion in totally unnecessary health-related economic expenses** to our already overburdened health care system and ailing economy.

Requiring smokers to pay only an **extra \$60/month for health insurance** -- a fraction of what they now pay on the average for tobacco products, and an even smaller fraction of the costs they impose on the great majority of Americans who are nonsmokers -- would bring in about **\$33 billion annually**; about the same as the proposed **"millionaires' tax,"** which is estimated to yield about \$35 billion/year.

Even requiring smokers to pay much less, **as little as \$220 more per year** [less than \$20/month] than nonsmokers for health insurance, would produce over **\$10 billion annually to help fund health care**. This is roughly comparable to extending the current **1.45% Medicare payroll tax to capital gains** earned by high-income taxpayers, which would also bring in about \$10 billion each year -- except that a user fee for smokers is not a tax, and therefore doesn't violate policies or pledges against new taxes.

Also, all of the **current fund-raising proposals** -- the "millionaires' tax," increasing the Medicare payroll tax, taxing health insurance benefits, a botox tax, etc. -- **do nothing whatsoever to directly reduce health care costs**, and have nothing whatsoever to do with personal responsibility.

SHOULD THERE ALSO BE A SURCHARGE ON OBESE PEOPLE?

As an organization devoted solely to the problem of smoking, **Action on Smoking and Health (ASH)** takes no formal position on other issues, including whether such a surcharge should extend to obese people, or even to other wellness factors. While we have no objection to such an extension of the principle, we do see both **important differences** and many **political reasons** why limiting the amendment at this time to smoking might be preferable.

Indeed, as **MSNBC** has just reported, a **majority of Americans favor charging smokers more for health insurance** as part of overall health care reform, but only 36% favor a similar surcharge on the obese. One possible reason, **MSNBC** suggests, is that two-thirds of Americans are overweight, but fewer than 20% still smoke.

Also, while the federal government has classified **smoking as a "behavior,"** obesity has been officially classified as a **"disease"** (for tax and Medicare purposes) and as a **"health status"** (for health insurance purposes). Thus imposing a surcharge on someone for having a "disease" or a "health status" might seem to be contrary to established government policy, or to simply be very unfair. SEE: <http://ash.org/higher4smokers>

Indeed, many people still believe (correctly or not) that obesity is often caused by heredity, genes, childhood eating, and other factors over which adult taxpayers have little if any control. On the other hand, most people see buying and using cigarettes as a habit or a choice, thus fitting the **criteria for a user fee**. Although there is evidence that for many people smoking involves addiction, the addiction is to the drug nicotine, not to the act of smoking itself, which is a behavior.

Because those who desire to can easily ingest nicotine from nicotine gum, nicotine patches, nicotine spray, and nicotine inhalers, their decision to ingest it by smoking rather than by using nicotine replacement products is a choice. Since it is a choice rather than an addiction, disease, or health status, it is **fairer to impose personal responsibility for the choice by making smokers bear at least a small portion of the huge costs** their choice imposes on the economy and the health care system.

Fewer than 20% of adults are smokers, and only about 13% smoke daily, while about 33% of adults are obese, and another 33% are classified as overweight. Thus the number potentially affected by a smoker surcharge is far smaller, and, because smokers are concentrated largely in the lower socioeconomic classes, they are less likely to be able to effectively object. A surcharge on the obese would arouse objections from a much larger segment of the population, including many people with considerable influence.

Those who wish to avoid a smoker surcharge can stop smoking, a process (though difficult for many) which usually occurs immediately ("cold turkey") or while undergoing a brief smoking cessation program. In contrast, few can cease being obese in a period of only weeks, and any attempt to do so quickly (e.g., because of financial pressure from a surcharge) is likely to have serious adverse health consequences, and result in even higher health care costs (at least for a brief period).

The model of a user fee on smokers (those who purchase and use tobacco products) does not fit as well (and is less capable of being argued) for obesity, since obesity can be and is caused by eating a wide variety of different kinds of foods, as well as by too many sedentary pass times, and by failing to engage in an even wider variety of activities (ranging from jogging to using the stairs). In short, one [smoking] involves nothing more than the choice not to use a single product; the other [obesity] involves numerous choices involving thousands of different products, lifestyles, and activities -- hardly the model for a user fee.

For similar reasons, it is likely that a proposed obesity surcharge would face a much larger, more powerful, and more diverse opposition from organized lobbying groups. A smoker surcharge would, at most, be opposed by the major tobacco companies, although the large pharmaceutical companies which manufacture nicotine replacement products are very likely to support it. In contrast, an obesity surcharge would likely be opposed by conventional and fast-food restaurant associations, soft drink makers, and by producers and distributors of a wide variety of foods which tend to be fattening.

Yes, we can determine who the smokers are. Insurance companies have long been able to determine who is (and who is not) a smoker, at least for the purpose of selling life insurance. Health professionals always ask about a person's smoking status, and such a status can be verified very easily with a blood, saliva, or urine test if necessary.

In contrast, determinations of obesity are complicated by widespread misunderstanding of the Body Mass Index [BMI] figure, and the fact that people may have a high BMI (but not an unhealthy percentage of fat) if they are quite muscular. Thus, while fair and objective determinations can be made in these situations by using more precise measures of body fat percentage (e.g., by using specialty bathroom scales or hand-held impedance devices), this all will be much more difficult to explain, and probably difficult for voters to accept.

If, despite these concerns, there is support for applying a surcharge to the obese as well as smokers, **ASH** certainly has no objection. However, initially restricting the surcharge to smoking alone, with the possibility of adding obesity (and perhaps even other factors) in following years as the concept gains even more public acceptance, and demonstrates its effectiveness in reducing overall health care costs, is an approach which should be considered.

COMPETING ARGUMENTS REFUTED

Some have argued that it is unfair to require people to pay more for health insurance simply because they choose to smoke. But we have long accepted the concept that it is fair and permissible to charge people more for life insurance (and, in some cases, even for automobile insurance) if they chose to smoke, just as we accept charging people more for home insurance if they decline to take certain fire-protection steps, more for auto insurance if they chose to drive dangerously and/or to purchase more-expensive-to-repair cars, etc.

Here it is also very important to note that the impartial **National Association of Insurance Commissioners [NAIC]** recommended that smokers should be charged more for health insurance, in part because they chose to smoke and because that choice imposes huge and unnecessary costs on others.

Some argue that it is unfair to impose a user fee on smokers because it will fall most heavily on the poor. But, to the extent that this is true, it is also beneficial and a sound health reform strategy since the poor and their families will benefit much more than the rich.

Surveys indicate that **most smokers already want to quit**, and imposing a surcharge will provide a strong incentive to help them; an incentive which obviously will be more effective for lower income families than for the wealthy.

Indeed, for many it will provide the first clear, direct, immediate, and inescapable reason for quitting. This is important because it appears that the incidence of smoking is highest among the poor, and that many other techniques or programs attempting to persuade this segment of the population to quit smoking are less effective.

Some might try to argue that a smoker user fee represents "big brotherism" -- the government intruding too far into personal lives. But government already does this in many far more intrusive ways when it is necessary to protect health: e.g.,

- * criminalizing the smoking of marijuana (which many argue is less dangerous than tobacco);
- * prohibiting the use of many drugs such as laetrile, even as a last resort to try to save the life of someone with a terminal disease;
- * requiring a prescription to use even very safe drugs like birth control pills or devices like nicotine sprays;
- * requiring adults (even when driving alone) to wear seat belts;
- * banning many flavorings in cigarettes, and authorizing the FDA to limit their nicotine content, etc.

A smoker surcharge is obviously far less intrusive, since it does not prohibit or restrict conduct -- it merely requires someone who chooses to smoke to bear personal responsibility by paying a small part of the cost his choice imposes on others, as does any other user fee.

To those who might try to argue that there might be administrative problems in determining who is a smoker, there are many simple answers.

First, most life insurance companies -- and even some health insurance companies -- already do it, thereby clearly demonstrating its feasibility.

Second, we know that applicants for insurance will almost always correctly identify themselves if they are smokers because their smoking habit is very well known to anyone who works or socializes with them -- unlike questions about whether or not one uses hard drugs, abuses alcohol, engages in unsafe sex, etc.

Third, anyone consulting a doctor, checking in to a hospital, or having any other major interaction with a health professional is already asked if they smoke.

Finally, if there is any doubt, one's status as a smoker can be easily and objectively verified by using a simple blood, urine, or saliva test for cotinine (with due allowance if those being tested can prove they are using nicotine patches or other similar devices).

SUMMARY OF PROPOSED AMENDMENT

ASH respectfully suggests that the arguments in favor of incorporating personal responsibility into health care reform by **requiring smokers to pay a modest surcharge** in the nature of a user fee are overwhelming.

It would **raise tens of billions of dollars** each year -- **without increasing taxes** -- to help pay for health care reform, while actually striking at the real heart of the problem by **reducing the diseases and other medical problems** the health care system is now required to treat; **something no other funding proposal even pretends to do.**

Thus **ASH** proposes a **surcharge (user fee)**, specified either as a percentage of the health insurance premium (e.g., 5%) or, alternatively, as a fixed dollar amount (e.g., \$60/month) on any **premiums paid by smokers for health insurance.**

The revenue would be paid to the government to help cover the enormous costs of health care reform, with a small percentage earmarked for antismoking and smoking cessation programs.

Action on Smoking and Health (ASH), America's first antismoking organization, is the organization behind the ban on cigarette commercials, restrictions on smoking in public places, legal actions against tobacco companies, and many other successful antismoking initiatives.

ASH is a national non-profit scientific and educational organization exempt from taxation as a publicly supported charity under Section 501(c)(3) of the Internal Revenue Code.