ISSUE PAPER:
Kentucky Omnibus Health Care Reform Act of 1986
Section 52

Section 52 of Kentucky's 1986 pre-filed health care legislation creates a new section of KRS 304.18. This section would require any group health insurance contracts in Kentucky to base premium rates in part on the use of tobacco and tobacco products.

The insurance industry, as a matter of sound business practice, generally does not base insurance rates on the use of particular products. It is commonly known that many products are, at one time or another, alleged to have side effects or defects, or are the center of controversy at a particular point in time. It would be imprudent, unfair, and highly arbitrary for the health insurance industry to adopt such procedures.

Beyond this, the problems with basing insurance rates on the use of tobacco fall primarily into two categories: (1) the equity of this kind of policy and (2) the administrative ramifications.

1. Equity

It is unfair and indeed constitutionally questionable to target one industry (and one group of people) with a mandate to market and manage its product in a particular manner. It is not the role of government to dictate marketing practices for the private sector by imposing unnecessary, indiscriminate, and unrealistic administrative constraints.

More importantly, this legislation is unfair to the insured:

Those who want to charge smokers higher health insurance premiums than nonsmokers generally base their argument on the assumption that smokers die earlier than those who do not smoke. Yet it has been consistently demonstrated that longevity has the greatest long-term impact on health insurance costs.

Therefore, if we accept the assumption that smokers die earlier than those who do not smoke, than nonsmokers:

- would use more health insurance and
- should bear the greater financial burden by paying higher premiums.

It has never been adequately demonstrated that smokers use more health insurance than those who do not smoke nor have studies attempting to establish a relationship between higher morbidity or mortality and smoking been conclusive.

The first study was conducted as early as 1967 by the Department of Health, Education and Welfare (HEW). The study, which became the basis for many claims about the total days smokers vs. nonsmokers stay at home because of illness or disability, suffered from serious flaws.

- The data clearly did not establish that cigarette smoking leads to increases in disease and disabilities. In fact it showed that female smokers, taken as a group, generally reported fewer diseases and disabilities and that moderate smokers very often reported the fewest number of diseases.

- The report gave inadequate attention to the effects of survey methods. There appeared to be many obvious sources of bias and error not taken into account.

In 1982, the Society of Actuaries created the Task Force on Smoker/Nonsmoker Mortality in an attempt to develop a valuation mortality standard for nonsmoker and smoker insurance products.

The group never produced concrete standards. In fact: it emphasized in the final report that the results produced "interim" valuation standards; that the report was "not the definitive statement with regard to separate valuation standards for smokers and nonsmokers;" and that there were "numerous areas in which more research is necessary."

Such research, apparently, has not been conducted.

More recently, in 1985, the Office of Technology Assessment (OTA), a research arm of the U.S. Congress, published a report entitled, "Smoking Related Death and Financial Costs." The report, which attempted to demonstrate that smoking contributed to higher health care costs, had some serious flaws, including blaming tobacco use for the death of many people who never used the product. Moreover, OTA relied on a combination of faulty research methods, such as:

- Almost exclusive reliance on a 25-year-old American Cancer Society (ACS) study that was unrepresentative of the U.S. population and an interpretation of some older studies;

- conducting no original research; and

- making unjustified assumptions e.g.; that the proportion of costs attributable to smoking is equal to the proportion of deaths related to smoking.

Even the author, Dr. Karl Kronebusch, acknowledged that the study had problems. He noted that all the calculations "...assume that nonsmoker death rates from the ACS study can be applied to the U.S. population." But, of course, it is obvious that such an assumption could never be made if a researcher intends to produce legitimate findings.

2. Administration Ramifications

The authors of this legislation apparently ignored the very obvious complexities associated with implementation and enforcement.

Several examples follow:

- If 20 employees out of a group of 100 smoke, should the higher premiums be developed and apply to the entire group or just to the 20 employees? What is the impact on group rate calculations? The proposed legislation provides no indication.

- Who would develop and manage the new accounting procedures for this kind of policy? The procedures would be cumbersome, complex, and difficult to implement.

  Who would be identified in a given group of smokers?

  How would a "price tag" be assigned to smokers?

In summary, any attempt by the government to mandate that the insurance industry base its rates on the use of tobacco -- or any other product -- would be unrealistic and unjustified.

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