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PEBA Tobacco Surcharge Study Committee
c/o Communications Department
PO Box 11661, Columbia, SC 29211-1661
VIA ELECTRONIC MAIL

Dec. 26, 2013

Members of the Committee:

My name is Eli Lehrer and I am president of the R Street Institute, a public policy think tank in Washington, D.C. I have read the report prepared by Gabriel, Roeder, Smith & Co. (GRS) to the Public Employees Benefit Authority that attempts to determine whether it would be in the best interest of South Carolina and the State Health Plan to differentiate among tobacco users based on the category of product used, such as by imposing a surcharge on users of higher-risk products.

I agree with the fundamental conclusion of the report that it is not currently possible to determine whether the State Health Plan should differentiate between types of tobacco users. However, I strongly suggest future study and analysis of this subject, and perhaps a pilot program that differentiates between types of tobacco use for a subset of state employees. I also believe one conclusion stated in the report may require further review.

R Street and its staff have done a significant research on South Carolina's insurance environment and on tobacco issues. As such, we are very well-situated to provide advice and guidance on this topic. Our associate fellows include two of the state's former insurance directors—Scott Richardson and Ernst Csiszar—and Dr. Joel NItzkin, a leading public health physician and expert on tobacco issues, serves as a senior fellow and member of our staff. In addition, I have written extensively about insurance issues and have written a paper, a copy of which is linked here, which explores a question closely related to the one you were tasked with answering.

As you see, the conclusion I reached is that, while no tobacco or nicotine product is fully safe, some forms are safer than others. Current research does not present an open-and-shut case in favor of differentiating between tobacco products in insurance premiums. Cigarette smokers in particular tend to be careless and engage in a variety of unhealthy behaviors beyond smoking. While some evidence suggests that those who quit do improve their overall well-being and health behavior, the data are neither sufficiently detailed nor sufficiently conclusive to draw firm conclusions.

That said, the benefits of differentiating between different tobacco products in terms of improved employee health and lower costs for the state's taxpayers could be significant, while the potential costs

seem quite small. In the best case, South Carolina could convince members of its workforce who find they cannot quit smoking to switch to other, less harmful tobacco and nicotine products. This would allow the state to reap both health premium cost savings and improved overall employee health. In the worst case scenario, a differentiated plan might encourage some employees to change the way they consume tobacco but would *not* produce health care costs saving or health benefits to the workforce. Even in this case, the state would be no worse off than it was before.

As such, it may make sense to proceed on a limited basis. The state is unlikely to be any *worse* off if it begins a process of differentiating between types of tobacco use (even if based solely on self-reported data) and can, indeed, overcome other legitimate barriers identified by GRS.

It is almost certainly correct, as GRS says, that existing data understate tobacco use by the state workforce and that the "all-or-nothing" attribution of tobacco use at the subscriber level presents significant problems. Likewise, existing medical data do not capture sufficient detail about the exact diseases caused by tobacco use in individual cases and many diseases related to tobacco use have other significant risk factors.

GRS, however, is not correct to say that "there is no reliable methodology for determining the form of tobacco associated with the contract (and the member)." While the blood and urine tests most commonly used to detect nicotine and its metabolite cotinine cannot distinguish between types of tobacco, commercially marketed medical equipment exists that can measure carbon monoxide in individuals' breath. These tests *can* distinguish between types of tobacco. All other things being equal, those who smoke tobacco will have higher levels of carbon monoxide in their breath than non-smokers, while carbon monoxide levels of those who use oral tobacco products will be the same as those of similarly situated non-smokers.

Since the state and its university system already perform drug tests on employees who hold commercial drivers' licenses or work in safety/security jobs, it would be a simple matter to add nicotine tests to the existing drug testing regime. Such tests could serve as the basis for a discount pilot program for people who use tobacco products other than cigarettes.

Under such a program, individuals that test positively for nicotine/cotinine but wish to qualify for a penalty smaller than that charged to smokers could then voluntarily submit to a carbon monoxide test. The cost of this additional testing would likely be trivial and, since it would have a financial payoff, would presumably be paid by employees themselves. To confront the all-or-nothing problem, an initial pilot program could include only contracts where the member is the only person covered.

Such a program would offer the state and its taxpayers the prospect of significant health insurance cost savings if it reduces disease caused by smoking. At worse, it would probably have no impact on state employees.

South Carolina has a good opportunity to educate its workforce about the differences between tobacco products. While barriers do exist to full-scale adoption of a penalty reduction for people who use tobacco

products other than cigarettes, they are not insurmountable. South Carolina shouldn't let the opportunity go to waste.

Yours truly,

Eli Lehrer
President
R Street Institute