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RE: AN ACT to amend the social services law and the insurance law, in relation to coverage for treatment of smoking cessation

A.693 (Jacobs)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the
Blue Cross and Blue Shield Plans

The Blue Cross and Blue Shield Plans of New York oppose the enactment of this bill which would require insurers to provide coverage for the cost of smoking cessation programs for their enrollees. Specifically, insurance plans would be mandated to provide four hundred dollars worth of coverage on an annual basis towards the cost of a prescription smoking cessation program. This bill would substantially increase the cost of insurance for consumers with little benefit to subscribers.

1. THE FAILURE RATES FOR SMOKING CESSATION PROGRAMS MAKE THIS A "REVOLVING" BENEFIT THAT INSURERS WOULD END UP PAYING FOR ON A REPEATED BASIS.

On an annual basis, roughly 20 million of the 50 million smokers in the United State attempt to quit smoking, but only 5% actually succeed in quitting on a long term basis. So few people successfully quit smoking that insurers would continually have to pay for smoking cessation programs. Approximately **70 to 80 percent** of smokers who use smoking cessation therapies will start to smoke again. (Jorenby et. al., A Controlled Trial of Sustained-Release Bupropion, a

Nicotine Patch, or Both for Smoking Cessation, The New England Journal of Medicine, 1999). The Surgeon General, in a report on smoking cessation, further stated:

> Tobacco dependence is best viewed as a chronic disease with remission and relapse. Even though both minimal and intensive interventions increase smoking cessation, most people who quit with the aid of such interventions **will eventually relapse and may require repeated attempts** before achieving long-term abstinence. Moreover, there is little understanding how such treatments produce their therapeutic effects. (*Emphasis added)*

The efficacy of smoking cessation programs is questionable at best. Studies are inconsistent as to which therapies actually work, and the duration of the effectiveness. For example, smokers who used a program which provided counseling and clinical interventions had a success rate of approximately 13.8% after six months. However, after one year, the group only had a successful quit rate of about 3.8%. (*See* Surgeon General's report *supra*).

Many of the studies conducted on the effectiveness of smoking cessation programs that conclude such programs are successful only take into account those smokers who are interested in quitting smoking. The effectiveness of smoking cessation programs for adolescent smokers, for smokers who are not interested in quitting smoking, or for those who repeatedly fail to quit is unclear. (Rigotti, The Treatment of Tobacco Use and Dependence, The New England Journal of Medicine, 2002).

Moreover, a recent study demonstrated that insurance coverage of smoking cessation therapies does not motivate enrollees to quit smoking. In fact, the study concluded that "the smoking-cessation benefit was not associated with any change in the use of smoking cessation devices." (Boyle, et. al., Does Insurance Coverage for Drug Therapy Affect Smoking Cessation?, Health Affairs, December 2002).

Although this bill contains a $400 annual benefit limit, the bill contains no provisions for a lifetime maximum benefit. Consequently, it is likely that these maximums will be reached every year. A commensurate increase in premiums will follow, making it still more difficult for individuals and small business owners to afford insurance.

2. LEGISLATIVE EFFORTS SHOULD ADDRESS AFFORDABILITY OF EXISTING BENEFITS, NOT CONTINUAL EXPANSIONS OF COVERAGE.

This bill represents yet another expansion of health care services that must be covered by all health insurance policies, at a time when many small employers and working families find it hard to afford basic health care coverage. Health benefit mandates increase the cost of health insurance for insurers which results in higher premiums for consumers. An increase in health insurance premiums typically translates into fewer individuals being covered by health insurance. A study by Sloan and Conover found that the higher the number of state mandated coverage requirements, the higher the probability that an individual was uninsured and the lower the

probability that he or she would have any private coverage. In order to ensure that the number of uninsured people in New York does not continue to escalate it is necessary to prevent the imposition of any new health benefit mandates.

Health benefit mandates also cause employers to decrease or drop coverage due to increased premiums. As premium prices increase to reflect the increase in health care costs, the number of employers who can afford such coverage decreases. Since 2000, there has been a 6% decrease in businesses providing health insurance coverage in New York. If costs continue to rise more employers in the state will face the real possibility of dropping coverage or passing the cost along to employees as rates continue to rise. These added costs will also contribute to an increase of uninsured New Yorkers—a figure that already stands at more than three million.

New York State already has over 40 mandated benefits that significantly increase the cost of health insurance. Benefit mandates lead to increased premiums, causing employers to reduce health benefits or drop them entirely, which in turn forces more working families to either purchase their own health insurance or become uninsured. Mandates such as this bill, however well-intentioned, increase insurance costs and make health care coverage even more unaffordable to consumers.

For all of these reasons, we oppose the enactment of this legislation.

Respectfully submitted,

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Blue Cross and Blue Shield Plans