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The University System of Georgia's Well-Being Policy Regarding Tobacco Product Use: A Proposal for Changing from Opt-Out to Opt-In

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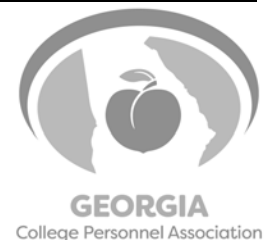
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The University System of Georgia (USG) has a state-wide initiative aimed at increasing the well-being of faculty and staff by incentivizing a decrease in tobacco product usage by employees covered by a USG healthcare plan. This incentive is positive in that aid in stopping tobacco product usage is offered to each member; and negative in that each member who is a tobacco product user is penalized. A healthcare surcharge is added to the monthly health insurance premium paid by each faculty/staff member for themselves and covered dependents over 18 years of age who are tobacco product users. The current policy considers covered employees and their applicable dependents to be users of tobacco products unless they annually opt-out. This paper includes summaries of the incidence of cigarette and tobacco product usage in the U.S., a summary of USG's policies related to the current tobacco initiative, a brief literature review regarding opt-in and opt-out programs, and a discussion of the possible negative impact of the current USG tobacco use policy. Support is provided for the present tobacco surcharge penalty being either eliminated or its implementation changed, and for the current opt-out default being changed to an opt-in program.

Key Words: Health Insurance, opt-in vs. Opt-out programs, tobacco product usage, tobacco use penalty, sin tax, regressive tax

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Despite cigarette usage in the United States (U.S.) having decreased since 1965 by 67% (ALA, n.d.), the use of tobacco products remains a leading cause of preventable diseases (CDC, n.d.). The University System of Georgia (USG) has a state-wide initiative (Well-Being Initiative, 2020) aimed at increasing the well-being of faculty and staff by incentivizing a decrease in tobacco product usage by those members covered by a USG healthcare plan. The incentive is both positive and negative: Positive in that aid in reducing tobacco product usage is offered to each member; and negative in that each member who is a tobacco product user is penalized. A healthcare surcharge is added to the monthly health insurance premium paid by each member for themselves and covered dependents over 18 years of age who are tobacco product users. The current Board of Regents (BOR) policy is to consider the member and applicable dependents as users of tobacco products unless the member opts out on an annual basis. That is, the default position is that the member is a user of tobacco products.

The authors propose that the default option be changed from assuming that members are tobacco product users (the opt-out option) to assuming that members are not users of tobacco products (the opt-in option). That is, changing from an opt-out to an opt-in default. With an opt-in program each

member who is a tobacco product user or has covered dependents over 18 years of age who are tobacco product users, would be required to opt into the program—annually declaring by opting-in that they are a tobacco product user. Therefore, our research question (RQ) is as follows:

RQ: Is there support for the USG Well-Being Initiative changing its tobacco use policy from an opt-out to an opt-in program?

In attempting to answer this question, this paper proceeds with summaries of the rate of occurrence (incidence) of both historical and current cigarette and tobacco product usage in the U.S., a summary of USG's policies related to the current tobacco Well-Being Initiative, a summary of USG employment, a literature review regarding opt-in and opt-out programs, a discussion of possible negative impacts resulting from the current USG tobacco use policy, and a conclusion which includes a proposal for either eliminating the surcharge or restructuring how it is determined, and for changing the USG tobacco use policy from an opt-out to an opt-in default.

Tobacco Use in the U.S.

As indicated in the selected data included in Table 1, the CDC (2018) reported the 2017 incidence of cigarette smoking in the U.S. at 15.8% for men and 12.3% for women. For age ranges between 35-65, which may

roughly approximate the ages of the majority of USG faculty and staff, the incidence of smoking is 9.0%-18.7% for men and 7.5%-16.0% for women. In other words, a high majority of both men and women in the U.S. do not smoke cigarettes. Compared to cigarette smoking rates in 1965 of 51.9% for men and

33.7% for women, there has been a notable decrease in cigarette smoking. A year-by-year analysis performed by the American Lung Association (ALA, n.d.) of CDC data indicated an overall decrease of 67% in cigarette smoking.

Table 1

Incidence of Cigarette Smoking (%) in the United States: 1965-2017. Selected demographics adapted from CDC (2018) Table 17 Trends Tables.

	1965	1979	1985	1990	2000	2005	2010	2014	2015	2016	2017
Gender											
Male	51.9	37.5	32.6	28.4	25.6	23.9	21.5	18.8	16.7	17.5	15.8
Female	33.7	30.1	27.9	22.9	21.1	18.3	17.5	15.1	13.8	13.7	12.3
Age (All Males)											
18-24	54.1	35.0	28.0	26.6	28.1	28.0	22.8	18.5	15.0	14.7	12.0
25-34	60.7	43.9	38.2	31.6	28.9	27.7	26.1	23.7	21.3	20.7	19.9
35-44	58.2	41.8	37.6	34.5	30.2	26.0	22.5	22.0	18.3	20.6	18.7
45-54	55.9	42.0	34.9	32.1	28.8	28.1	25.2	19.9	18.3	19.1	17.5
55-64	49.6	36.4	31.9	25.9	22.6	21.1	20.7	18.8	17.5	19.7	17.3
≥65	28.5	20.9	19.6	14.6	10.2	8.9	9.7	9.8	9.7	10.1	9.0
Age (All Females)											
18-24	38.1	33.8	30.4	22.5	24.9	20.7	17.4	14.8	11.0	11.5	8.8
25-34	43.7	33.7	32.0	28.2	22.3	21.5	20.6	17.5	15.0	13.9	13.0
35-44	43.7	37.0	31.5	24.8	26.2	21.3	19.0	17.0	16.5	15.4	12.9
45-54	37.5	32.6	32.4	28.5	22.2	20.9	21.3	18.7	18.4	18.5	15.2
55-64	25.0	28.6	27.4	20.5	20.9	16.1	16.5	14.8	13.7	15.0	16.0
≥65	9.6	13.2	13.5	11.5	9.3	8.3	9.3	7.5	7.3	7.7	7.5

As of November 15, 2019, the latest data available, the CDC's Morbidity and Mortality Weekly Report (MMWR, 2019) indicated

(Table 2) a further decrease in the incidence of cigarette smoking to an overall rate of 13.7%: 15.6% for men and 12.0% for

women. However, taking into account all forms of tobacco usage, which includes E-cigarettes, the rates were 25.8% for men and 14.1% for women. The overall tobacco usage was 23.8% for ages 25-44, and 21.3% for ages 45-64. On a regional basis, the Southern region had an overall rate of tobacco product usage of 21.4% which was higher than the rates in the Northeast and

West regions but lower than the rates in the Midwest region. Of interest to the present study, adults with graduate degrees, which would include almost all instructional faculty, had the lowest incidence of the usage of cigarettes and all tobacco products: 3.7% for cigarette use and 8.2% for the use of any tobacco product (MMWR, 2019).

Table 2

2018 Incidence of Tobacco Product Usage in the United States

	Any Tobacco Product (%)	E-Cigarettes (%)	Cigarettes (%)
Overall	19.7	3.2	13.7
Gender:			
Male	25.8	4.3	15.6
Female	14.1	2.3	12.0
Age:			
18-24	17.1	7.6	7.8
25-44	23.8	4.3	16.5
45-64	21.3	2.1	16.3
≥65	11.9	0.8	8.4
Census Region:			
Northeast	17.5	2.2	12.5
Midwest	23.6	4.0	16.2
South	21.4	3.5	14.8
West	15.3	2.9	10.7
Education (adults ≥ 25 yrs.):			
0-12 (no diploma)	25.9	2.5	21.8
GED	41.4	-	36.0
High school diploma	25.2	2.7	19.7
Some college, no degree	24.7	4.1	18.3
Associate degree	21.3	3.0	14.8
Undergraduate degree	13.0	2.2	10.6
Graduate degree	8.2	-	3.7

Source: Selected data adapted from CDC Morbidity and Mortality Weekly Report (MMWR), November 15, 2019

USG Well-Being Tobacco Use Policy

While the incidence of tobacco product usage in the U.S. continues to decline, the USG's 2020 Wellness Initiative includes a punitive policy regarding the use of tobacco products by faculty and staff. According to Chancellor Wrigley, "the goal of the USG Wellness Initiative is to increase opportunities for our employees to participate in a program that will assist them to lead happier and healthier lives as well as aid in reducing personal and healthcare costs" (Chancellor's Letter, n.d., para. 3). Currently, the tobacco product usage policy is an opt-out program. Employees and staff who are covered by a USG healthcare plan and who do not use any form of tobacco products must certify that they and their covered family members, which includes dependents who are over 18 years of age, are not tobacco users. The default position is that the faculty/staff and their applicable dependents are tobacco users. The surcharge for family tobacco users is \$100 per month per person. According to the USG's Tobacco Use Certification Information (USG Well-Being, 2020), faculty/staff who are deemed (including errors in not opting out) tobacco users will "each month . . . pay between \$100-\$300 (or more in some cases) in additional surcharges, depending on how many people are covered by . . . [the] USG healthcare plan. No refunds will be given" (pp. 2-3). Consequently, a member with a spouse and three dependents over 18 years

age who are all tobacco users would pay \$500 per month in surcharges or \$6,000 per year. Thus, a faculty or staff member who makes an inadvertent error in not opting out could pay dearly, and this error cannot be retroactively reversed. New hires and covered family members who are not tobacco users must opt-out within 30 days of being employed. All other faculty must complete tobacco use certification information (opt-out or be defaulted in) each year during the health care enrollment period (USG Well-Being, 2020).

A USG employee who fraudulently opts out of being a tobacco product user can be subject to criminal prosecution. That is, an employee who falsely certifies that they (including covered dependents who are 18+ years of age) are not tobacco users are subject to criminal prosecution. The Tobacco Use Certification Information specifies the false opt-out penalty as follows:

If you knowingly and willfully make a fraudulent statement to the University System of Georgia regarding your insurance coverage, including your status as a tobacco user, you may be subject to criminal prosecution.

Under state law (at O.C.G.A. Section 16-10-20), if convicted, you shall be punished by a fine of no more than \$1,000.00 or by imprisonment for no less than one nor more than five

years, or both. (USG Well-Being, 2020, para. 11)

In addition, having been found guilty of an ethics violation or a criminal offense the policy may subject faculty and staff to disciplinary actions including termination of employment. The ethics policy contained in Section 8.2.18.1 of the Code of Conduct of the BOR's Policy Manual requires, in part, that "member[s] of the USG community . . . comply with all applicable laws, *rules, regulations*, and professional standards" [emphasis added]. In addition, the BOR's Policy Manual (BORPM: 8.3.9.1) in part indicates that grounds for the removal of faculty include "conviction or admission of guilt of a felony . . . during the period of employment . . . [and] violation of Board of Regents' policies" Under Georgia Code Title 16, Crimes and Offenses § 16-11-131 a felony is

defined as ". . . any offense punishable by imprisonment for a term of one year or more and includes conviction by a court-martial under the Uniform Code of Military Justice for an offense which would constitute a felony under the laws of the United States" (FindLaw, n.d.). Thus, faculty and staff found guilty of lying about their use of a tobacco product could potentially be terminated.

USG Employment

As of fall semester 2019 the USG had a total of 49,541 employees. Of this number, 11,851 were full-time instructional faculty with the remainder composed of 1,550 other instructional faculty and 36,140 non-instructional employees. Faculty members were predominately male (53.8%) and had graduate degrees (97.9%). A summary of USG employment data is presented in Table 3

Table 3.

USG Employees Fall 2019

Full-Time Faculty		11,851
Gender		
Male	6,372	
Female	5,469	
Other	10	
Education		
Graduate Degree	11,599	
Undergraduate Degree	252	
Other Instructional Faculty		1,550
Temporary	479	
Other	1,071	
Non-Instructional employees		36,140
Total Employees		49,541

Source: USG Faculty Data (n.d.)

Opt-In Opt-Out Literature Review

As previously indicated, the authors suggest that the USG change their tobacco product usage policy from an opt-out to an opt-in program. Accordingly, a review of the literature was undertaken. This review indicated that the published research on opt-in and opt-out choices is scant. When presented with a decision, either of the two choices can be used as a default option. In theory these choices neither affect relative prices nor supply and demand. However, outcomes can be greatly affected by an opt-out default option as inertia can result in greater participation (e.g., McMichael, 2008; Rutecka-Gora et al., 2018). As indicated below, many opt-out policies are instituted to produce a perceived “good” for the individual (e.g., pension or savings plan participation) or for society (e.g., the availability of organs for transplant).

Inertia, which is defined by Merriam-Webster dictionary as including an “indisposition to motion, exertion, or change,” is a widely accepted phenomenon that affects many consumers (Johnen, 2019). The opt-out system is being used in many areas whereby overcoming inertia it directly benefits the consumer. In the case of pension coverage an opt-out option can improve the outcome for individual employees since an opt-in system can result in some employees, those who fail to sign up because of inertia, being left without coverage (Rutecka-Gora et

al., 2018). On the other hand, Rutecka-Gora et al. (2018) suggested that an opt-in default comes with implicit fixed or barrier costs that can prevent an individual from making the most beneficial choice. These barriers include costs of obtaining information relevant to participation and investment choices and of becoming knowledgeable about investing.

McMichael (2008) provided another example of an opt-out program being used to overcome inertia. The U.S. Department of Defense supported an opt-out default for their Thrift Savings Plan (TSP)—a plan that provided troops with tax-free earnings at retirement. McMichael suggested that through an opt-out default sign up process troop inertia worked to their benefit by providing retirement earnings that could have inadvertently been lost. That is, members of the military were deemed by default to agreeing to participate in the TSP. To change their participation status, they had to opt-out of the plan.

Much of the literature regarding default options relate to organ donations. Ferguson et al. (2020) argued that in this regard an opt-in system presents a free-rider problem where individuals that have not opted-in still benefit from the system. That is, at no cost to themselves free riders receive a potential benefit. The larger the donor base, the greater the availability of organs. In addition, by the free rider not opting into organ donation, others may be discouraged from

registering or may decide to deregister. An opt-out system generally has significantly more individuals signed up for organ donations than does an opt-in default (Davidai et al., 2012). StanfordISPARQ (n.d.), a self-styled “do tank,” suggested that the U.S. should change from an opt-in to an opt-out organ donation policy. They indicated that such a change would increase the U.S. organ donation rate from around 15% to about the 90% donation rate found in opt-out countries. In addition, Shepherd et al. (2014) found that “opt-out consent is . . . associated with an increase in the total number of livers and kidneys transplanted” (p. 10).

By providing more in short supply organs for transplant, it can be argued that an opt-out policy provides a public good. Nevertheless, organ donation is an intimate personal decision. Due to reasons such as distrust of the medical profession and religious objections, many people do not want to donate their organs. Distrust of the medical profession includes donor questions about brain death versus death from one’s heart stopping, and whether non-organ donors might be kept alive longer (Wen, 2014). According to Bruzzone (2008), “no religion forbids donation or receipt of organs or is against transplantation” (p. 1064). However, some sects of Judaism and Islam proscribe directed organ donation and transplantation (Bruzzone, 2008). Nevertheless, people may still object

to organ donation based on their personal religious beliefs. For example, Wen (2014) noted that “. . . Catholics are less likely to donate than other religious groups. . .” (para. 11). Thus, an opt-out policy could inadvertently result in organ donations by people who object to having their organs taken—a potential public injustice that must be weighed against the potential for public good.

In regard to organ donations, a default also virtue signals or recommends a certain action (Johnson & Goldstein, 2003). If the default is to opt-out then the government has made a conscious choice for its citizens that suggests a best practice, namely the donation of organs. This accepted and virtuous choice needs no additional input from the citizen rather an individual who wishes not to donate organs would have to make a conscious decision and take action in order to opt-out. In the case of making this selection when applying for a driver’s license several barriers may exist. The selection may not be entirely anonymous if the individual has to communicate the choice to a clerk or complete the form in public and pass it to the clerk for data entry. Further, the license may state the selection publicly, which creates an additional hurdle to choosing contrary to the accepted default. Under an opt-out system for organ donations, each citizen potentially benefits from the organ donations of others directly or indirectly. When opting

out of the organ donation program one might be seen as a “free rider” who may consume benefits without incurring any cost.

Opt-out defaults can also have real costs for consumers. In the example of Medicaid managed care, Marton et al. (2017) described how the auto sign up for Medicaid plans benefited neither the system by keeping costs low nor the average consumer by covering their needs. Inertia caused most individuals to remain in their auto assigned plans. Only the highest cost individuals changed their plans which resulted in adverse selection and individual plan margin declines.

In some instances, however, opt-out defaults along with inertia are used specifically to achieve higher payments while providing fewer average benefits, seemingly under a profit motive. For example, Bibby (1994) described the credit industry practice in the United Kingdom (U.K.) of automatically selling payment protection insurance policies to customers who bought on credit. Credit plan protection insurance was sold under an opt-out system where the consumer had to act (actively indicate no) in order to not be charged the extra insurance fee. Consumers usually had to tick a small box on their credit application in order to opt-out of the payment protection insurance. However, most consumers were not aware of this option and so unknowingly purchased the insurance. This

practice was determined inappropriate by the Office of Fair Trade in the U.K. and lenders were told to switch to an opt-in arrangement (Bibby, 1994).

In another example from Canberra, Canada, the practice of mandatory student unionism was abolished for an opt-out union fee system. The opt-out system was selected over an opt-in system expressly for the purpose of keeping memberships and fee revenues at ‘useful’ levels. This change suggests that decision makers believed that an opt-in default would not collect sufficient revenues, and that inertia was counted on to subsidize otherwise unsustainable fee revenues (“Power play a test for O’Farrell,” 2008).

Estimated Impacts of the Tobacco Surcharge Incidence of Tobacco Product Usage

The incidence of cigarette smoking has tremendously decreased over the past 50 years (Table 1). In 1965, 51% of males and 33.7% of females smoked, while in 2017 only 15.8% of males and 12.3% of females smoked. In other words, 84.2% of men and 87.7% of females do not smoke cigarettes. However, in recent years other tobacco products, such as E-cigarettes, have become popular as cigarette substitutes. The 2018 incidence of tobacco product usage was 25.8% for males and 14.1% for females. Tobacco product usage in the southern region of the U.S.

averaged 21.4% (Table 2). Therefore, the vast majority (78.6%) of adults in the Southern region do not use tobacco products.

The level of one's education influences the incidence of tobacco product use. As indicated in Table 2, adults with a GED have the highest rate (41.4%), adults with an undergraduate degree have a lower rate (13.0%), and adults with a graduate degree have the lowest rate (8.2%). As presented in Table 3, 11,599 of 11,851 (97.9%) of the faculty in the USG have graduate degrees and 252 (2.1%) have undergraduate degrees. This data suggests that about 91.7% of full-time USG instructional faculty probably do not use tobacco products: 11,851 total full-time faculty, less 13% of faculty with undergraduate degrees, less 8.2% of faculty with graduate degrees equals 10,867, divided by 11,851 equals 91.7%.

Estimated Tobacco Use Surcharges

The present authors have requested that the BOR provide the total amounts of surcharges paid by USG members since the Well-Being Initiative (2020) was implemented and to provide information regarding the number of USG employees covered by a USG health insurance plan. This data has not been forthcoming. Therefore, in Table 4, estimates are provided. These calculations were made using the following assumptions:

1. Total number of full time USG employees at 47,991, which is, per Table 3, composed of 11,851 full time faculty and 36,140 non-instructional employees. "Other instructional faculty" of 1,055 were not included. According to the USG Faculty Data (n.d.) "other instructional faculty" are not full-time faculty and thus are probably not eligible to participate in a USG health plan.

2. Eighty percent of faculty are covered by a USG health insurance plan. This is a very conservative estimate. Perhaps well over 90% of USG full time employees take advantage of the health insurance benefit.

3. Estimated tobacco usage rates of 20%, 15%, and 10%. The top rate of 20% is a rounded estimate based on a weighted average of 20.4% computed using national statistics (Table 2) and the gender of fulltime faculty (Table 3), which was the only gender information available. A rounded upper estimate of 20% seems to be further supported by the CDC MMWR (2019) data that indicates 21.4% of adults in the Southern Region of the U.S. use a tobacco product (Table 2). The low percentage of 10% is a rounded estimate of tobacco product usage based on the weighted average of 8.3% estimated for full time faculty who have undergraduate or graduate degrees plus an arbitrary addition of 1.7% for staff. The 15% percentage is the midpoint percentage. Again, the actual

percentage of faculty and staff who use tobacco products was not provided by the BOR.

4. Tobacco surcharge amounts are based on one to five covered employees and their dependents.

As shown in Table 4, at a 20% estimated tobacco product usage rate, and depending on the total number of members covered, the total annual tobacco use surcharges range from \$9,214,800 for one

member covered to \$46,074,000 for five members. At an estimated 15% rate, the range is \$6,909,600 to \$34,548,000; and at an estimated 10% rate, the range is \$4,606,800 to \$23,034,000. Conservatively estimating that only one to two covered members pay the surcharge and using the three estimated rates provides the following ranges: \$4,606,800-\$9,213,600 at 10%, \$6,909,600-\$13,819,200 at 15%, and \$9,214,800-\$18,429,600 at 20%.

Table 4

Estimated Tobacco Surcharges Paid Under Various Assumptions

Estimated Tobacco Usage Rates	*Estimated No. of Covered Employees Impacted (A)	Total Members Covered (B)	Amount per Month (C = B x \$100)	Annual Amount (D = C x 12)	Potential Totals (A x D)
20%	7,679	1	100	\$1,200	\$ 9,214,800
	7,679	2	200	\$2,400	\$18,429,600
	7,679	3	300	\$3,600	\$27,644,400
	7,679	4	400	\$4,800	\$36,859,200
	7,679	5	500	\$6,000	\$46,074,000
15%	5,758	1	100	\$1,200	\$ 6,909,600
	5,758	2	200	\$2,400	\$13,819,200
	5,758	3	300	\$3,600	\$20,728,800
	5,758	4	400	\$4,800	\$27,638,400
	5,758	5	500	\$6,000	\$34,548,000
10%	3,839	1	100	\$1,200	\$ 4,606,800
	3,839	2	200	\$2,400	\$ 9,213,600
	3,839	3	300	\$3,600	\$13,820,400
	3,839	4	400	\$4,800	\$18,427,200
	3,839	5	500	\$6,000	\$23,034,000

*Assumptions: Approximately 80% of 47,991 USG employees (Table 3) are covered by a USG sponsored health insurance program: full time faculty (11,851) + non-instructional employees (36,140) x .80 = 38,393; .20 x 38,393 = 7,679; .15 x 38,393 = 5,758; .10 x 38,393 = 3,839.

Potential Windfall to Insurance Companies

The present authors have been unable to obtain data from the BOR regarding the amount of tobacco surcharges paid by USG employees. While we believe that the failure rate (percentage of eligible employees who inadvertently fail to opt-out) is probably small, the total dollar amounts of tobacco surcharges paid by non-tobacco users can still be significant. We have estimated the total dollar amounts using the same assumptions as in Table 4 of 47,991 full-time employees with one to five covered members. In addition, we

have estimated failure to opt-out rates (failure rates) of 1%, 0.5%, and 0.25%. The actual rate of USG employees inadvertently failing to opt-out of being tobacco product users has not been provided by the BOR.

The results, as presented in Table 5, indicate that at an estimated failure rate of 1%, the total dollar amounts range from \$460,000 to \$2,304,000. At a .05% failure rate, the total amounts range from \$230,000 to \$1,152,000; and at a .25% failure rate the amounts range from \$115,200 to \$576,000. Of course, the actual failure rate could be higher than 1% or lower than .25%.

Table 5

Estimated Windfall to Insurance Companies of Employee Inadvertent Failure to Opt-Out as a Tobacco User: Estimates Using Various Assumptions

Estimated Opt-Out Failure Rate	*Estimated No. of Covered Employees Impacted (A)	Total Members Covered (B)	Amount per Month (C = Bx\$100)	Annual Amount (D = C x 12)	Potential Totals (A x D)
1%	384	1	\$100	\$1,200	\$ 460,800
	384	2	\$200	\$2,400	\$ 921,600
	384	3	\$300	\$3,600	\$1,382,400
	384	4	\$400	\$4,800	\$1,843,200
	384	5	\$500	\$6,000	\$2,304,000
.5%	192	1	\$100	\$1,200	\$ 230,400
	192	2	\$200	\$2,400	\$ 460,800
	192	3	\$300	\$3,600	\$ 691,200
	192	4	\$400	\$4,800	\$ 921,600
	192	5	\$500	\$6,000	\$1,152,000
.25%	96	1	\$100	\$1,200	\$ 115,200
	96	2	\$200	\$2,400	\$ 230,400
	96	3	\$200	\$3,600	\$ 345,600
	96	4	\$200	\$4,800	\$ 460,800
	96	5	\$200	\$6,000	\$ 576,000

*Assumptions: Approximately 80% of 47,991 USG employees (Table 3) are covered by a USG sponsored health insurance plan: full time faculty (11,851) + non-instructional employees (36,140) x .80 = 38,393; .01 x 38,393 = 384; .005 x 38,393 = 192; .0025 x 38,393 = 96

Estimated Individual Costs

Failure to opt-out of being a tobacco user can result in egregious penalties. Depending on the number of family members covered by a USG insurance sponsored plan, the monthly surcharge is \$100-\$500, assuming a maximum number of covered members at five (this number could actually be higher). The annual amounts range from \$1,200 to \$6,000. While these raw amounts appear impactful, the potential negative impact on

USG employees is perhaps better illustrated as a percentage of average salaries.

The percentages of average instructional faculty salaries represented by annual tobacco surcharges of \$1,200 to \$6,000 are presented in Table 6. The higher the faculty's salary the lower the percentage impact of the surcharge. The lowest is 0.76% for professors at research institutions, while the highest is 12.82% for instructors/lecturers at state colleges.

Table 6

Estimated Tobacco Surcharge Impact on Faculty of as a Percentage of Average Salaries

Type of Institution and Surcharge for 1-5 People Covered	Average Salaries*/% of Salary			
	Professor	Associate Professor	Assistant Professor	Instructor/ Lecturer
Research Universities	\$158,190	\$116,700	\$110,377	\$67,199
\$1,200 (x1)	.76%	1.03%	1.09%	1.79%
\$2,400 (x2)	1.52%	2.06%	2.17%	3.57%
\$3,600 (x3)	2.28%	3.08%	3.26%	5.36%
\$4,800 (x4)	3.03%	4.11%	4.35%	7.14%
\$6,000 (x5)	3.79%	5.14%	5.44%	8.93%
Comprehensive Universities	\$89,077	\$73,262	\$67,473	\$51,401
\$1,200 (x1)	1.35%	1.64%	1.78%	2.33%
\$2,400 (x2)	2.69%	3.28%	3.56%	4.67%
\$3,600 (x3)	4.04%	4.91%	5.34%	7.00%
\$4,800 (x4)	5.39%	6.55%	7.11%	9.34%
\$6,000 (x5)	6.74%	8.19%	8.89%	11.67%
State Universities	\$79,213	\$65,382	\$60,224	\$48,723
\$1,200 (x1)	1.51%	1.84%	1.99%	2.46%
\$2,400 (x2)	3.03%	3.67%	3.99%	4.93%
\$3,600 (x3)	4.54%	5.51%	5.98%	7.39%
\$4,800 (x4)	6.06%	7.34%	7.97%	9.85%
\$6,000 (x5)	7.57%	9.18%	9.96%	12.31%

State Colleges		\$72,181	\$63,730	\$60,211	\$46,801
	\$1,200 (x1)	1.66%	1.88%	1.99%	2.56%
	\$2,400 (x2)	3.32%	3.77%	3.99%	5.13%
	\$3,600 (x3)	4.99%	5.65%	5.98%	7.69%
	\$4,800 (x4)	6.65%	7.53%	7.97%	10.26%
	\$6,000 (x5)	8.31%	9.41%	9.96%	12.82%

* Source: USG Average Instructional Faculty Salaries 2019.

The present authors have not been able to obtain average salaries for non-instructional employees. Nevertheless, non-instructional members who earn similar salaries would pay the same rates. For example, if an instructional or a non-instructional member earns \$50,000, the range of surcharges produce rates of 2.4%, 4.8%, 7.2%, and 12%.

Discussion

No matter how one looks at the national data presented in Table 2, and assuming that USG member tobacco usage is in accord with national data, the great majority of USG plan members are probably not users of tobacco products. Overall, 80.3%, and by Southern region 78.6%, of adults do not use tobacco products. Breaking the data into the demographic areas of gender and education provides even larger percentages of non-tobacco product usage. By gender, male non-usage is at 74.2% and female non-usage is at 85.9%. By education, for faculty members, of whom 97.9% hold a graduate degree (USG Faculty Data, n.d.; cf. Table 3), non-

usage is at 91.7%. Therefore, based on national rates of tobacco product usage, the default position of opt-out (which assumes that all faculty members are tobacco users) is not warranted. Tobacco product usage data thus supports an opt-in rather than an opt-out program.

With group plans, insurance companies use group averages to calculate risk-based premiums (Cogan, 2018). In a given year individuals that do not have claims subsidize the costs of those that do. On average, younger group members subsidize older group members. The tobacco surcharge can be likened to the risk adjustment made by automobile insurance companies based on the individual's driving record. With the tobacco use surcharge insurance companies have added an individual risk into the member's insurance premium, which essentially decreases the beneficial effects of group subsidy.

The tobacco surcharge can also be viewed as a punishment for a certain behavior. Tobacco usage is already curtailed by various laws. For example, laws commonly

restrict tobacco usage to certain areas. Moreover, “sin” taxes have long been imposed on the purchase of cigarettes. Federal and state excise taxes currently account for about half of the cost of a pack of 20 cigarettes. In 2019, Georgia cigarette consumers paid a total tax of \$13.76 per 10-pack carton (Cammenga, 2019). The negative consequences imposed are inherently meant to cause behavioral changes that result in less tobacco product usage.

The question arises about other behaviors that lead to negative health effects and the selective targeting of tobacco usage. While tobacco usage has been on the decline, obesity, which was described by McCafferty et al. (2020) as a “. . . a public health epidemic in the United States. . .” now affects 39.8% of the population and is expected to affect about 53% of the population by 2030 (p. 1). Sedentary behavior and excessive intake of calories, sugar, and alcohol can all lead to negative health outcomes. Nevertheless, tobacco usage is singled out as a punishable behavior worthy of a surcharge. Why is there not also a surcharge for other forms of health issues that are under the control of the member? By the same reasoning, should a surcharge not also be levied on members based on their self-reported caloric intake, on the number of alcoholic drinks they self-report as consumed each week, or on self-reported levels of exercise?

The tobacco use surcharge provides a substantial benefit to insurance providers. As indicated in Table 4, it is estimated that USG members annually pay millions of dollars in tobacco surcharges. How do these surcharge payments benefit USG members? First, it can be argued that this penalty works to disincentivize tobacco use, which is a major cause of preventable diseases. By decreasing tobacco product usage, both the individual and society benefit. Second, by agreeing to impose this surcharge, the BOR was perhaps able to negotiate lower insurance premiums for non-tobacco users.

While the tobacco surcharge may be considered to encourage a social good (less tobacco product usage), an opt-in program would do the same. Changing to an opt-in program would not eliminate the surcharge imposed on members who use tobacco products. In addition, if the tobacco surcharge was changed to an opt-in rather than an opt-out program, total amounts of surcharges collected by insurance providers should not be lessened. Assuming that members are truthful in reporting their tobacco usage, which is assumed in the current opt-out program, insurance providers would collect the same revenues. Lying in reporting tobacco usage is already disincentivized by the possibility of the member being criminally prosecuted and losing their job. This penalty applies whether or not the member lies to opt-

out or lies to not opt-in. Inadvertent errors by non-tobacco users in failing to opt-out produces an ongoing punishment—one that lasts for at least a year—since the election can only be changed during an annual enrollment period and cannot be retroactively corrected. Hence, insurance providers can substantially benefit from member error. Such errors can be minimized by adopting an opt-in program.

Members who are users of tobacco products pay a severe penalty. Since surcharges are fixed amounts, they disproportionately impact members with lower salaries. As indicated in Table 6, the lower the average salary, the higher the percentage represented by the tobacco surcharge—in effect, the surcharge can be likened to a regressive tax. Based on type of institution and employment level, the tobacco surcharge paid by faculty represents 1% to 12.8% of their salaries. Similar rates would also apply to non-instructional faculty with comparable salaries. As previously indicated, a single member without dependents who uses tobacco products and earns an annual salary of \$50,000 pays a surcharge that represents 2.4% of their salary. In comparison, the maximum Georgia income tax rate in 2019 was 5.75%. Are the surcharge amounts fair and reasonable? The authors suggest that for USG members with relative lower salaries, the answer is no; at the very least, the

surcharge can be characterized as potentially burdensome.

In addition, members who inadvertently fail to opt-out are, without recourse, locked into paying the surcharge for an entire year, and perhaps longer if they miss the next opt-out opportunity. Notably, failure to opt-out results in the surcharge being levied on not only the member but also on all the member's applicable dependents. As indicated in the above literature review, opt-out programs can benefit the consumer (e.g., pension plans, saving plans) by providing a valuable benefit; or they can be used to take advantage of inertia which results in increased provider revenues (e.g., payment protection insurance, increased union fees). The USG's opt-out policy is of the latter type. Such surcharge payments—those paid due to member error—create a “windfall” for the insurance companies—what might be characterized as an ill-gotten increase in insurance company gross margins (Table 5). An opt-in program would eliminate tobacco surcharges caused by member error.

Ethics is another consideration that should be taken into account in deciding to change to an opt-in program. As indicated in the literature review, organ donors who may be opposed to donating their organs can be trapped into agreeing to do so by an opt-out program. This adverse effect is often dismissed by using a “greater good” argument.

The tobacco surcharge is different. An opt-out program for tobacco product usage is more like the example of U.K. borrowers being tricked into purchasing unwanted insurance. An opt-out program for tobacco product usage mainly benefits the bottom line of insurance providers. Indirectly, non-smokers may benefit (probably minimally, if at all—it is unlikely that this windfall is passed on to members) through lower premiums from member error in not opting out. Even if this is the case, is this treatment fair and equitable? There is no benefit to non-smokers of being charged a tobacco surcharge. Is it the right thing to do to severely penalize a member for inadvertently not opting out as a tobacco user and by so doing secure a benefit for the good of the many—perhaps, only secure a benefit for the insurance provider? Changing to an opt-in policy eliminates the possibility of this ethically questionable consequence.

Conclusions and Proposals

The opt-out assumption that defaults to all members being tobacco users is not supported by national tobacco product usage data—rather, the opposite is true. Changing from the current opt-out program to an opt-in program would not affect insurance company revenues—the same amounts should be collected under either approach. Alternatively, a ‘sticky’ default could be used where an employee makes a selection once and that

selection carries forward automatically until it is changed. An option without a default would also be feasible where a simple yes/no question about tobacco usage would be required to be answered before a member could gain access to the open enrollment portal, essentially eliminating the user error scenario. It appears that a major driver of an insurance company preference for an opt-out program is the collection of revenues from members who unwittingly fail to opt-out. The penalty paid by those who fail to opt-out is severe. Lastly, the ethics of subsidizing premium costs by taking advantage of member error should be considered.

In answer to the research question (RQ), the authors believe that there is ample support for the USG changing their Well-Being Initiative tobacco use policy from an opt-out program to an opt-in program. The assumption should be that the member and their dependents are not tobacco product users unless the member affirmatively declares differently. The non-tobacco preference should become the default for the following health plan year. This is similar to the dependent election. Once a dependent is entered, they remain a dependent by default for each subsequent plan year.

In addition, the authors suggest that policy makers reconsider the levying of the surcharge. Tobacco and cigarette users are already penalized by being restricted in

where they can use the products. Cigarette users already pay high excess taxes— “sin” taxes. Moreover, tobacco users are continually warned by their doctors and through the media about the negative consequences of their bad habit. Does an additional penalty, especially a severe one such as USG’s tobacco surcharge, really decrease the incidence of tobacco product usage? Friedman et al.’s (2016) results regarding the market place implementation of the Affordable Care Act’s (ACA) tobacco surcharges suggest that tobacco use cessation is not incentivized by surcharges:

Relative to those facing no surcharges, smokers facing medium or high surcharges had significantly reduced coverage (-4.4 to -11.6 percentage points), but no significant differences in smoking cessation. Taken together, these findings suggest that tobacco surcharges conflicted with a major goal of the ACA— increased financial protection—without increasing smoking cessation. (Friedman et al., 2016, p. 1176)

Moreover, should tobacco product users be targeted for a penalty while numerous other potentially health-related behaviors are not? Surcharges in general decrease the beneficial effects of insurance premiums being computed on group averages. The present authors suggest that the imposition of the

tobacco surcharge penalty is a slippery slope, which could lead to other surcharges being negotiated by insurance companies. In the opinion of the authors, the best solution is for no surcharges to be imposed.

Even if the tobacco surcharge penalty is not eliminated, policy makers should reconsider the way the penalty is implemented. As currently structured the penalty can be severe, especially to members who earn relatively lower salaries. The fixed amounts of the tobacco use surcharge, like excise taxes (e.g., “sin” taxes) and sales taxes (Tax Foundation, n.d.), are regressive. That is, the less the member earns, the larger the percentage of their income that is represented by the surcharge. As indicated in Table 6, the tobacco surcharge penalty can amount to a significant percentage of a member’s annual salary.

Limitations

This research was limited by a lack of access to pertinent data. As of the present writing, the authors have not been able to obtain information regarding the total number of employees covered by a USG-sponsored health insurance plan, the total amount of instructional and non-instructional surcharges paid by year, and various demographic data for non-instructional employees. Therefore, estimates were necessitated regarding the total tobacco surcharges paid by members, the

potential windfall to insurance companies of members indivertibly failing to opt-out, and

the tobacco surcharge impact on faculty as a percentage of average salaries.

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