Note

Healthy Compromise: Reconciling Wellness Program Financial Incentives with Health Reform

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Soaring health care expenditures[1] coupled with plummeting insurance coverage[2] suggest something is seriously wrong with the American health care system. In 2010, President Barack Obama and Congress responded with the passage of the Patient Protection and Affordable Care Act (ACA)—redesigning the health care system to increase access to affordable health insurance and care for all Americans.[3] One way that the ACA

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1. Total health care expenditures in 2011 continued to grow. In 2011, health care spending totaled $2.7 trillion, which is 17.9% of the Gross Domestic Product. CTR. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2011 HIGHLIGHTS 1, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf; CTR. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2010–2020, at para. 4, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2010.pdf ("By 2020, national health spending is expected to reach $4.6 trillion and comprise 19.8% of GDP.").

2. In 2010, there were 49.9 million uninsured Americans compared to 45 million uninsured in 2008. U.S. CENSUS BUREAU, P60-239, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 23 (2011), *available at* http://www.census.gov/prod/2011pubs/p60-239.pdf.

3. *See* President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009) ("[Health reform] will provide more security and stability to those who have health insurance. It will

proposes to control health care costs is through support for employee wellness program initiatives.[4] While wellness programs existed prior to the ACA, the Act encourages large employers to adopt wellness programs as a means to decrease health care costs.[5] These programs control costs by persuading employees to adopt healthier, and hopefully medically cheaper, lifestyles.[6]

Wellness programs may be structured to incentivize participation in activities like educational sessions.[7] They may also be structured to incentivize the attainment of certain health outcomes, like a desirable blood pressure or cholesterol level.[8] The incentives themselves can be as simple as a gym membership or the opportunity to participate in classes, but they also may be more economically valuable.[9] For example, the ACA potentially more than doubles the premium discount available to participants who achieve desirable health status indicators.[10] Employers and insurers are now permitted to provide rewards potentially worth up to 50% of a successful employee-participant's health insurance premium.[11] This Note concerns this type of financially incented program.

Curbing health care costs is doubtlessly important.[12] But wellness programs risk creating unproductive financial barriers to health care by using health insurance to single out and discriminate against individuals with poor health statuses. This

provide insurance for those who don't. And it will slow the growth of health care costs for our families, our businesses, and our government.").

4. The ACA defines a wellness program as "a program offered by an employer that is designed to promote health or prevent disease." 42 U.S.C. § 300gg-4(j) (Supp. 2012).

5. *See* Kristin M. Madison et al., *The Law, Policy, and Ethics of Employers' Use of Financial Incentives to Improve Health*, 39 J.L. MED. & ETHICS 450, 451 (2011) ("The [ACA] both reflects and promotes growing interest in employer incentive programs.").

6. *Id.* at 453.

7. 42 U.S.C. § 300gg-4(j)(2)(E).

8. *See* Madison et al., *supra* note 5, at 451.

9. *See* 29 C.F.R. § 2590.702(f)(1)(i)–(v), (2)(i) (2006). For example, a wellness plan may encourage preventative care by waiver of copayments for prenatal care or well-baby visits, or provide for economic rewards of up to 20% of the cost of coverage under the plan in exchange for participating in the program. *Id.*

10. *See* Madison et al., *supra* note 5, at 462.

11. While the ACA prescribes a 30% value limit, it allows the maximum value to be raised to 50% at the discretion of the Secretaries of Labor, Health and Human Services, and the Treasury. *Id.* at 451.

12. *See, e.g.*, Thomas Bodenheimer et al., *Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job?*, 28 HEALTH AFF. 64, 64 (2009).

Note challenges the popular sentiment that these programs are a promising solution to the issues of unhealthy employees and expensive health care.[13] It suggests that financially incented wellness programs are ill-suited to achieve the dual aim of improving health and saving money because the legal and policy tensions these programs create threaten to undermine the ACA's goal of promoting health and preventing disease.[14]

Wellness programs structured to incentivize health by providing financial rewards for healthy outcomes are problematic on two levels. First, the discriminatory nature of the program requirements potentially conflict with existing statutes, namely, the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA).[15] Second, the wellness provisions are in tension with the purpose of wellness programs generally, as well as with the broader purpose of the ACA.[16] These problems will be exacerbated if the ACA is successful in increasing the number of employers offering significant financial rewards to healthy employees through wellness programs.[17]

Part I of this Note gives some background on health insurance, discusses wellness programs under HIPAA and the ACA, and explains the evolution of wellness programs in American insurance schemes. Part II examines how the ACA's wellness provisions conflict with existing laws and how the provisions are internally inconsistent. Part III concludes with some ideas about how the ACA's wellness provisions can be improved to better balance the statutory objectives of promoting healthy living without unduly burdening the unhealthy. Suggestions include remedying confusing statutory language and taking a more conservative approach to implementing programs with significant financial incentives through controlled pilot pro-

13. *See, e.g.*, Wendy K. Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 DUQ. L. REV. 271, 299–301 (2012) (describing large employer enthusiasm for wellness programs with incentives for participation). This article by Mariner ultimately presents a thesis very similar to this Note: that health insurance is not a good vehicle for health status stratification. *Id.* at 330. This Note makes a novel contribution by providing a more detailed and technical look at wellness programs that discriminate based upon health status factors using financial incentives while Mariner's article mainly approaches the problem from higher level insurance theory.

14. *See* 42 U.S.C. § 300gg-4 (Supp. 2012).

15. *See infra* notes 73–74, 89 and accompanying text.

16. *See infra* Part II.C.

17. *See* Madison et al., *supra* note 5, at 451.

grams, rather than granting all employers general permission (and even encouragement) to proceed.

I. THE STRUCTURE AND FUNCTION OF WELLNESS PROGRAMS

It is important to understand some basic principles of health insurance before exploring the problematic nature of employer wellness programs with financial incentives for health status attainment. After establishing this foundational background, this section explains Congress's purpose for enacting both the ACA and the provision governing wellness programs. This section next contrasts this purpose with that of the original wellness program regulation under HIPAA. Finally, this section examines in greater detail the history and evolution of wellness program legislation.

A. A HEALTH INSURANCE PRIMER

Some basic background information about how health insurance works is helpful to understanding wellness programs' role in the insurance system and how the programs' financial incentives can adversely affect the group health insurance market. Financial incentives are created by discounting the price of insurance using differential premiums, copayments, and deductibles.[18] A premium is the amount a purchaser pays for an insurer to assume the risk of the purchaser's health care expenses[19] while a copayment is a fixed amount a policyholder must pay at the time he or she receives certain health care services.[20] A deductible is the total amount that a policyholder must pay out-of-pocket before an insurance plan will begin covering services.[21] While premiums, deductibles, and copayments are standard elements of most insurance plans, state and fed-

18. Janet L. Doglin & Katherine R. Dieterich, *Weighing Status: Obesity, Class and Health Reform*, 89 OR. L. REV. 1113, 1133 (2011).

19. *See* STEVEN PLITT ET AL., 5 COUCH ON INSURANCE 3D § 69:1 (2012).

20. BLACK'S LAW DICTIONARY 385 (9th ed. 2009).

21. *Id.* at 475.

eral laws[22] require plans to completely cover certain preventive services without copayments or deductibles.[23]

Private health insurance can be offered either as part of an individual or group plan.[24] Most Americans are covered by group insurance.[25] Group plans are generally provided by an employer.[26] Individual plans are sold to people who do not have employer insurance either because they are self-employed, unemployed, or because their employer does not provide health insurance benefits.[27] Group plans pool risk among all members—everyone in the group pays the same monthly insurance premium calculated using an estimation of the average cost of everyone in the group.[28] Individual plans have traditionally been priced using underwriting.[29] Underwriting practices base cost upon the estimated risk of the purchaser.[30] This allows insurers to "issue, decline, or differentially price insurance based

22. The law governing insurance plans depends upon a plan's structure. The ACA wellness program provisions are applicable to all types of health insurance. See Lucinda Jesson, *Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations*, 15 VA. J. SOC. POL'Y & LAW 217, 241–42, 245–46 (2008), for a concise explanation about when insurance plans are subject to state versus federal law.

23. 42 U.S.C. § 300gg-13(a)(1) (Supp. 2012) (listing the mandatory covered services to include "A" or "B" rated services as designated by the United States Preventive Services Task Force, certain immunizations, certain preventative services for infants and children, and certain women's preventative services); CCH, 2010 TAX LEGISLATION: PATIENT PROTECTION AND AFFORDABLE CARE, HEALTH CARE RECONCILIATION, HIRE, AND OTHER RECENT TAX ACTS ¶ 530 (CCH Editorial Staff eds., 2010); Jesson, *supra* note 22, at 241–42 (describing common state coverage requirements). Two examples of preventive services include screening for abdominal aortic aneurisms in smokers, and screening and counseling for childhood obesity. U.S. PREVENTATIVE SERVICES TASK FORCE A & B RECOMMENDATIONS, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last visited Mar. 11, 2013) (listing mandatory coverage services).

24. Anne Maltz, *Health Insurance 101*, *in* INSURANCE LAW 2007: UNDERSTANDING THE ABC'S 263, 272 (PLI Litig. and Admin. Practice, Course Handbook Ser. No. 11214, 2007).

25. *See* Mark V. Pauly & Bradley Herring, *Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market*, 26 HEALTH AFF. 770, 770 (2007).

26. *See id.* at 771.

27. *See id.* at 771–72.

28. Amy B. Monahan, *Health Insurance Risk Pooling and Social Solidarity: A Response to Professor David Hyman*, 14 CONN. INS. L.J. 325, 326 (2008).

29. Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1885 (2011).

30. *Id.*

on an individual's prior health experience or expected risk."[31] Group plans pool risk more effectively than individual plans.[32] Large groups distribute risk better than small groups because the risk is spread among more individuals.[33] A final unique characteristic of group, as opposed to individual, health insurance is that group health insurance receives a significant federal tax subsidy.[34] In 2007, the Joint Committee on Taxation estimated there was more than $245 billion in tax expenditures associated with the current health insurance tax scheme.[35]

The ACA makes significant changes to the structure of the American health insurance system. After 2014, in order to avoid a fine, all Americans above a threshold income level must obtain insurance coverage, and all businesses with a certain number of employees must provide coverage for their workers.[36] The Act also creates state insurance exchanges.[37] These exchanges increase the opportunity for competitive pricing, informed insurance policy selection, centralized administration, and uniform regulation for individual insurance.[38] The purchase mandate combined with state health insurance exchanges better aggregates the cumulative risk of people seeking individual policies;[39] the exchanges create risk pools more akin to group insurance risk-sharing and also control administrative

31. *Id.*

32. *Id.* at 1884–85.

33. *See id.*

34. See Fred T. Goldberg, Jr. & Susannah Camic, *Tax Credits for Health Insurance*, 37 J. L. MED. & ETHICS 73, 74–75 (2009), for a summary of the employer health insurance tax subsidy.

35. *Id.* at 75.

36. 26 U.S.C. § 5000A (Supp. 2012) (mandating individual coverage); 26 U.S.C. § 4980H(a) (Supp. 2011) (requiring large employers to offer minimal health care coverage). *See generally* CCH, *supra* note 23, at ¶¶ 405, 415, 425 (summarizing and explaining the ACA coverage requirements).

37. 42 U.S.C. § 1396w-3(b) (Supp. 2012).

38. *See* THE HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM, EXPLAINING HEALTH CARE REFORM: WHAT ARE HEALTH INSURANCE EXCHANGES? 1 (2009), *available at* http://www.kff.org/healthreform/upload/7908.pdf.

39. *See* 42 U.S.C. § 18091(2)(J) (Supp. 2012) ("By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums."); Melinda Beeuwkes Buntin et al., *The Role of the Individual Health Insurance Market and Prospects for Change*, 23 HEALTH AFF. 79, 88 (2004).

costs.[40] The Act also contains medical loss ratio requirements that strictly limit the proportion of insurer costs that may be used to contribute to overhead and other administrative expenses.[41] One purpose of these changes is to restructure the individual health insurance market to more closely resemble the large group market, both in terms of the amount of risk-sharing happening, and the tight control of underwriting and underwriting-like practices.[42]

B. WELLNESS PROGRAMS AFTER THE AFFORDABLE CARE ACT

It is difficult to directly ascertain Congress's intent in passing the ACA because of the Act's meager legislative record.[43] The partisan discourse that makes up the record reflects the fact that the ACA was passed through both congressional houses in a sharply divided political environment—leaders agreed that the health system needed reform, but disagreed when it came to how best to effectuate change.[44] An inquiry beyond the

40. *See* 42 U.S.C. § 18091(2)(J) ("Administrative costs . . . are 26 to 30 percent of premiums in the current individual and small group markets."); M. Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*, 18 HEALTH AFF. 28, 32–33 (1999) ("The administrative expense . . . of nongroup insurance [is] often said to be high—as much as half of premiums . . . —while that of group insurance can fall to about 5 percent in very large groups.").

41. In large group plans 85% of the premium cost must be allocated to health service delivery, while in small group plans and the individual market, 80% of the premium costs must be so allocated. 42 U.S.C. § 300gg-18(b)(1)(a) (Supp. 2012).

42. *See* Hoffman, *supra* note 29, at 1887.

43. *See* Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 527, 554 (2011) ("For a law whose provisions are highly complex and whose enactment was undoubtedly one of the hardest fought in U.S. history, the [ACA] is remarkably short on legislative history.").

44. 156 CONG. REC. E508 (daily ed. Mar. 25, 2010) (statement of Rep. Jeb Hensarling) ("Republicans agree that we must reform health care in America. The current system is unsustainable, and simply doing nothing is not an option."); 156 CONG. REC. H2430 (daily ed. Mar. 25, 2010) (statement of Rep. Mike Pence) ("Reject this attempt to fix a government takeover of health care. Work with us to repeal and start over on health care reform that reflects the common sense and the common values of the American people."); 156 CONG. REC. H2432 (daily ed. Mar. 25, 2010) (statement of Rep. Jim Langevin) ("This Congress is being given a once-in-a-lifetime opportunity to fix a broken health care system that has left millions of families without the coverage and care they deserve."); 156 CONG. REC. H2433 (daily ed. Mar. 25, 2010) (statement of Rep. Silvestre Reyes) ("I heard from many El Pasoans who shared their struggles under the current broken health insurance system."); 156 CONG. REC.

sparse official record shows that the Act was designed to both slow health care spending and increase Americans' healthy years of life through regulation, preventative care, and health promotion activities.[45] One of the ACA's central objectives is to make health care more affordable and accessible to all Americans.[46] Implicit in this objective is the significance of the ACA's commitment to individuals in poor health—the group facing the most adversity in the traditional health care system.[47]

The remainder of this section describes the current law governing wellness programs, explains the history of wellness plan regulation, and concludes with demographic data suggesting wellness programs have the potential to significantly alter the health insurance landscape after the ACA.

1. The Present State of the Law

Wellness programs were first introduced as an exception carved out of the antidiscrimination provisions in the Health Insurance Portability and Accountability Act (HIPAA).[48] Wellness programs were described in detail in the HIPAA regulations.[49] Most recently, the programs were codified in the ACA with few, yet significant, changes.[50] The ACA defines a wellness program as "a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection."[51] The ACA recognizes two types of wellness programs: those that condition rewards on

H2436 (daily ed. Mar. 25, 2010) (statement of Rep. Brian Bilbray) ("It is no secret that the health care system is in need of reform . . . . While we can argue over many points, there is one issue where there is no debate: we need health care reform."); CCH, *supra* note 23, at 1–2.

45. *See generally* Gwendolyn Roberts Majette, *PPACA and Public Health: Creating a Framework to Focus on Prevention and Wellness and Improve the Public's Health*, 39 J.L. MED. & ETHICS 366 (2011) (describing the extent of congressional consideration of public health issues and Congress's understanding of the critical importance of health care reform).

46. *Id.* at 373.

47. *Cf.* Thomas More Law Ctr. v. Obama, 651 F.3d 529, 570 (6th Cir. 2011) ("When healthy individuals opt not to buy health insurance, the pool of insured persons is smaller and less healthy as a whole, thus raising premiums."); Hoffman, *supra* note 29, at 1914–22 (discussing "financial security" policies in the ACA).

48. The HIPAA anti-discrimination provision is explained *infra* in the text accompanying notes 73–74.

49. NANCY LEE JONES ET AL., CONG. RESEARCH SERV., R40661, WELLNESS PROGRAMS: SELECTED LEGAL ISSUES 1–5 (2010).

50. *Id.* at 1–2.

51. 42 U.S.C. § 300gg-4(j)(1)(A) (Supp. 2012).

health status factors, and those that do not.[52] There are few restrictions on programs that do not condition rewards on health status factors.[53]

A program offering a reward based upon a health status factor must meet five conditions: (1) the reward must not be more than 30% of the cost of coverage;[54] (2) the program must "be reasonably designed to promote health or prevent disease";[55] (3) eligible individuals must have the opportunity to qualify for the reward annually;[56] (4) the reward must "be made available to all similarly situated individuals";[57] and (5) materials describing the terms of the program must disclose the availability of a "reasonable alternative standard" or possibility of waiver for those for whom it would be impossible or unsafe to achieve the given standard.[58] These requirements are supposed to minimize discrimination against unhealthy individuals.[59] A closer examination of the first, second, and fourth conditions is helpful to better understand how the statute operates.

The first condition limits the value of the reward that a wellness program may offer participants. Even beyond the 30% of premium cost maximum, the ACA allows the limit to be increased to 50% of the cost of coverage with the approval of the Secretaries of Labor, Health and Human Services, and the Treasury.[60] Employers may elect to offer this premium differential either as a penalty for people failing to meet a wellness ob-

52. *See id.* § 300gg-4(j)(1)(B)–(C). Examples of programs that do not condition rewards upon health status factors include a program that pays for a gym membership, a program that gives a reward for participation in diagnostic testing, or a program that covers the costs of participation in smoking cessation counseling. *Id.* § 300gg-4(j)(2)(A)–(B), (D).

53. *See id.* § 300gg-4(j)(1)(B) (describing the only restriction as the requirement that a program must be "made available to all similarly situated individuals").

54. "Cost of coverage" is equal to the total of both employer and employee contributions to the insurance plan. *Id.* § 300gg-4(j)(3)(A).

55. *Id.* § 300gg-4(j)(3)(B) ("A program complies with [this provision] if [it] has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the manner chosen to promote health or prevent disease.").

56. *Id.* § 300gg-4(j)(3)(C).

57. *Id.* § 300gg-4(j)(3)(D).

58. *Id.* § 300gg-4(j)(3)(E).

59. *See* Jesson, *supra* note 22, at 248.

60. 42 U.S.C. § 300gg-4(j)(3)(A).

jective or as a discount to people who do.[61] However the differential is formulated, the effect is the same: individuals who are unable to achieve the standards will pay more for health insurance.[62] In some instances, wellness savings may be significant enough to completely cover the cost of the employee's premium.[63]

The second condition provides some assurance that the program will be designed in a way that actually improves participants' health. The statute itself states that this condition ought to be interpreted liberally: the standard is whether "the program has a reasonable chance" of improving health or preventing disease.[64] The same subsection requires that the program cannot be "overly burdensome," a "subterfuge for discriminating based on a health status factor" or "highly suspect" in the method chosen to achieve its goal.[65]

The fourth condition requires that the reward be made available to "all similarly situated individuals." To satisfy this condition, the program must provide a "reasonable alternative standard," or waiver of the standard, for individuals for whom achieving the standard is either "unreasonably difficult due to a medical condition" or "medically inadvisable."[66] The veracity of this information may be verified from the participant's physician,[67] a caveat that significantly curtails the routine use of this exception to casually circumvent cost differentials.[68]

In November 2012, the Secretaries of the Department of the Treasury, Department of Labor, and the Department of Health and Human Services issued a proposed regulation governing wellness programs.[69] The proposed regulations state that the maximum differential will be maintained at the statu-

61. *See* Madison et al., *supra* note 5, at 459–60 ("[I]t is not clear that all carrots are created equally, as they can often be reframed easily as sticks. . . . [T]he effect of a penalty incentive program may be to transform a wage differential into an insurance premium differential.").

62. *Id.*

63. Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1603 (2011).

64. 42 U.S.C. § 300gg-4(j)(3)(B).

65. *Id.*

66. *Id.* § 300gg-4(j)(3)(D)(i)(I)–(II).

67. *Id.* § 300gg-4(j)(3)(D)(ii).

68. *See* Mariner, *supra* note 13, at 285 (noting that a plan may require a physician's recommendation for qualification).

69. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 Fed. Reg. 70,620 (proposed Nov. 26, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–47).

tory minimum of 30% of the cost of coverage except in the case of smoking.[70] The premium differential for smokers is greater, up to 50% of the total cost of coverage.[71] Further, the proposed regulations provide detail about what will and will not be considered a reasonable alternative standard for people under the condition requiring that rewards be made available to "all similarly situated individuals."[72]

2. The Evolution of Wellness Program Regulation and Litigation

The regulation of wellness programs was born from an exception to HIPAA group insurance antidiscrimination requirements. HIPAA contains a general prohibition forbidding all group insurance plans or issuers from discriminating against policyholders based upon health status.[73] This general rule is subject to an important exception: wellness programs that meet the requirements set forth in the HIPAA regulations, and now the ACA, do not have to comply with the antidiscrimination provisions.[74]

HIPAA was passed in 1996.[75] It was not until 2006, however, that the regulations promulgating wellness programs were released.[76] In 2007, two bills with provisions highly supportive of wellness programs and similar initiatives were considered, though neither was enacted.[77] In 2010, the ACA codified the HIPAA regulations with two important differences: (1) the ACA raised the reward maximum from 20% to 30% of the total cost of the premium and added administrative flexibility by allow-

70. *Id.* at 70,623–24.

71. *Id.*

72. *Id.* at 70,624–25.

73. 29 C.F.R. § 2590.702(b)(1)(i) (2012); *see also* Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,017 (Dec. 13, 2006) ("The HIPAA nondiscrimination provisions generally prohibit a plan or issuer from charging similarly situated individuals different premiums or contributions based on a health factor.").

74. 29 C.F.R. § 2590.702(f); *see also* 71 Fed. Reg. at 75,017 ("The HIPAA nondiscrimination provisions do not prevent a plan or issuer from establishing discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to [wellness programs].").

75. Health Insurance Portability and Accountability Act, Pub. L. No. 104–191, 110 Stat. 1936 (1996).

76. 29 C.F.R. § 2590.702.

77. *See* Majette, *supra* note 45, at 368. These bills were the Healthy Lifestyles and Prevention America Act, S. 1342, 110th Cong. (2007), and the Healthy Workforce Act of 2007, S. 1753, 110th Cong. (2007). *Id.* at 368 nn.20–21.

ing the Secretaries to increase this limit to 50%;[78] and (2) the ACA provided for a ten-state demonstration project extending the wellness program provisions to individual insurance plans.[79] The ACA also provides grants to small employers without wellness programs to implement "comprehensive workplace wellness programs" consistent with criteria to be delineated by the Secretary of Health and Human Services.[80]

HIPAA legislative and administrative records elucidate the underlying purpose of a wellness program exception. The HIPAA Senate Report says of the programs,

> Because of the difficulty of constructing language which allows such beneficial practices to continue, while prohibiting plan designs and practices that are intended to discriminate based on health status or other related factors . . . the legislation expressly allows employee health benefit plans and health plan issuers . . . to modify premiums, copayments, and deductibles in return for adherence to [wellness programs].[81]

The background information introducing the final 2006 HIPAA regulations provides additional information about the rationale behind the reward limit, explaining that the purpose of the cap is "to avoid a reward or penalty being so large as to have the effect of denying coverage or creating too heavy a financial penalty."[82] The regulations' background also observes that "[t]he 20 percent limit on the size of the reward in the final regulations allows plans and issuers to maintain flexibility in their ability to design wellness programs, while avoiding rewards or penalties so large as to deny coverage or create too heavy a financial penalty . . . ."[83] Initially, proposed regulations suggested lower percentage choices of 10% and 15%, but after rulemaking comments submitted by employers and the insurance industry the final limit was fixed at 20%.[84] In 2006, premium discounts at the 20% level potentially generated an average payment difference of $920 per participant per year.[85] The 2006 Regulations

78. *Compare* 42 U.S.C. § 300gg-4(j)(3)(A) (Supp. 2012) (30% maximum), *with* 29 C.F.R. § 2590.702(f)(2)(i) (20% maximum).

79. 42 U.S.C. § 300gg-4(l).

80. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10408(c), 124 Stat. 119, 977 (2010).

81. S. REP. NO. 104-156, at 19 (1995).

82. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,018 (Dec. 13, 2006).

83. *Id.*

84. *Id.*

85. *Id.* at 75,021.

emphasize that the "reasonable design" requirement[86] should be liberally construed, and that there is no need for "a scientific record that the method promotes wellness to satisfy this standard."[87] Ultimately, wellness programs are regulated to ensure "fewer instances in which [they] shift costs to high-risk individuals, and more instances in which these individuals succeed at improving health habits and health."[88]

Wellness programs with financial incentives have the potential to clash with anti-discrimination provisions in the Americans with Disabilities Act (ADA). Congress enacted the ADA to prevent discrimination against people living with a wide variety of disabilities.[89] The ADA states,

> A covered entity[90] shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature of the severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.[91]

The ADA does not explicitly mention wellness programs,[92] but the programs are addressed in the ADA's legislative history. The House Report explains that in order to be ADA-compliant, wellness programs monitoring health status factors such as weight and cholesterol must be voluntary, confidential, and may not limit insurance eligibility or prevent professional advancement.[93] While the legitimacy and scope of wellness pro-

86. 42 U.S.C. § 300gg-4(j)(3)(B) (Supp. 2012).

87. 71 Fed. Reg. at 75,018.

88. *Id.* at 75,020.

89. *See* JONES ET AL., *supra* note 49, at 6–7; *see also* H.R. REP. NO. 101-485, pt. 2, at 22–23 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 304 ("The purpose of the ADA is to provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life; to provide enforceable standards addressing discrimination against individuals with disabilities, and to ensure that the Federal government plays a central role in enforcing these standards on behalf of individuals with disabilities. The ADA defines 'disability' to mean, with respect to an individual: a physical or mental impairment that substantially limits one or more of the major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment.").

90. A covered entity is defined as a "health plan," a "health care clearinghouse," and "[a] health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter." 45 C.F.R. § 160.103 (2011).

91. 42 U.S.C. § 12112(d)(4)(A) (2006).

92. *Id.*

93. H.R. REP. NO. 101-485, pt. 2, at 51, *reprinted in* 1990 U.S.C.C.A.N. 303, 357.

grams have yet to undergo extensive judicial examination, the first such case to be heard in federal court involved an allegation of an ADA violation.

The first, and presently only, case to grapple with the ACA's wellness provisions is *Seff v. Broward County*.[94] *Seff* was a class action lawsuit initiated by past and present employees of Broward County contesting the legality of a $20 penalty for non-participation in an employee wellness program.[95] The plaintiff contested the program's use of a medical examination and questionnaire.[96] The plaintiffs claimed that the penalty violated the ADA by effectively making the examination and questionnaire compulsory.[97] The court acknowledged that the ADA creates a safe harbor for wellness programs that meet two requirements: (1) the program must either be a term in a bona fide benefit plan or a plan itself;[98] and (2) the program must be "based on underwriting risks, classifying risks, or administering such risks."[99]

The *Seff* court found the program met both safe harbor requirements. The court held that the wellness program was clearly a term in a benefit plan, and may even be considered a benefit plan unto itself because of the disease coaching and medication cost waiver benefits for participants.[100] The court also held that the program was based on "accepted principles of risk assessment" both because it collected aggregated data for analysis using risk classification techniques to develop future benefit plans, and because it was designed to control risk by making the insured population healthier, and therefore less expensive to cover.[101] *Seff* suggests that courts may be friendly to wellness programs, at least in the context of the ADA. Wellness program litigation, however, has yet to be developed and it is too early to determine how these programs will fare in the courts.

94. 778 F. Supp. 2d 1370 (S.D. Fla. 2011).
95. *Id.* at 1371.
96. *Id.* at 1371–72.
97. *Id.* at 1372.
98. *Id.* at 1373–74; *see also* 42 U.S.C. § 12201(c) (Supp. 2011).
99. *Seff*, 778 F. Supp. 2d at 1373–74; *see also* 42 U.S.C. § 12201(c).
100. *Seff*, 778 F. Supp. 2d at 1373 n.5.
101. *Id.* at 1374.

3. Trends in Population Health and Wellness Program Prevalence

In 2005, over 130 million Americans were afflicted with a chronic condition, and by 2020, this number is expected to increase to 157 million.[102] Spending on chronic illness is estimated to increase by 42% between 2003 and 2023.[103] The burden of illness is not evenly distributed across the population: multiple health determinants—including an aging population and workforce, an increasingly obese population,[104] wealth, and race—affect who is most likely to experience poor health.[105] Health determinants significantly affect health disparities: over 30% of adults living below the federal poverty level suffer from activity limitations related to chronic illness, while only 10% of adults over 400% of the federal poverty level are so afflicted.[106] Moreover, people with poor health statuses—who tend also to be poorer financially—already pay more for health care in both raw dollars, and percentage of income, contributed to health care expenditures through deductible and copayment costs.[107]

Considering the deteriorating health of Americans and the rising cost of care, it is unsurprising that employers are embracing wellness program to control costs and increase worker productivity. Between 2004 and 2006, the number of large employers[108] offering employee incentives for healthy behaviors increased from 7% to 19%, and between 2006 and 2007 the number of large employers offering premium differentials as a wellness reward increased.[109] In 2007, almost 40% of employers without wellness programs reported an intention to pay em-

102. Bodenheimer et al., *supra* note 12, at 64.

103. *Id.* at 65.

104. *Id.* at 65.

105. *See, e.g.*, Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, 21 HEALTH AFF. 60, 60–61, 70 n.60 (2002).

106. ROBERT WOOD JOHNSON FOUND., OVERCOMING OBSTACLES TO HEALTH 21 (2008), *available at* http://www.rwjf.org/content/dam/farm/reports/reports/2008/rwjf22441.

107. Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 U. ILL. L. REV. 1159, 1166–70 (2012).

108. A "large employer" is defined as an employer with at least 500 employees. Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359 NEW ENG. J. MED. 192, 192 (2008).

109. *Id.*

ployees for biometric wellness achievements within the next three years.[110]

The changes the ACA makes to the American insurance system, the increasing prevalence of chronic illness, and the rising popularity of wellness programs together suggest that wellness programs will have a significant role in the future of American health insurance and health care.[111] The current program structure, however, is self-contradictory and risks exacerbating health disparities rather than improving the health of the population.

II. THE PROBLEM WITH FINANCIALLY INCENTED WELLNESS PROGRAMS

This section examines how the current wellness program regulations create technical and ideological issues with other regulatory schemes. It first considers how the wellness provisions may conflict with existing law and then examines how the provisions operate in relation to the ACA.

A. LEGAL ISSUES

Wellness programs with aggressive financial incentives implicate statutes that protect certain types of people and information, like the ADA.[112] Additionally, these programs conflict with the original purpose envisioned for them by HIPAA, and with the overarching goals of the ACA itself.

1. Wellness Programs and the Americans with Disabilities Act

The discriminatory nature of premium differentials based on health status potentially clashes with the ADA. The ADA's legislative history and the United States Equal Employment Opportunity Commission's (EEOC) guidance both require that

110. Madison et al., *supra* note 5, at 451 (citing NAT'L BUS. GRP. ON HEALTH & TOWERS WATSON, THE ROAD AHEAD: SHAPING HEALTH CARE STRATEGY IN A POST-REFORM ENVIRONMENT 15 (2011), *available at* http://www.thehortongroup.com/Files/41c8e753-70d4-b602-38db-15481ad7e12d.pdf).

111. *See* Michelle M. Smith, *Making Wellness Programs Work Well*, OCCUPATIONAL HEALTH & SAFETY (June 2011), http://ohsonline.com/Articles/2011/06/01/Making-Wellness-Programs-Work-Well.aspx.

112. While there has been little litigation about these potential issues to date, this may change in light of the ACA's push for more wellness programs with greater financial differentials.

wellness programs be voluntary.[113] The EEOC guidance says a program is voluntary "as long as an employer neither requires participation nor penalizes employees who do not participate."[114] Wellness programs with aggressive financial incentives push the boundary between voluntary and coercive. The permissible financial differentials are not minimal and have substantially increased after the ACA.[115] It is not difficult to imagine that a court could find that a wellness program with significant financial incentives, although ostensibly voluntary, in reality functions as a mandatory wellness program, and thereby runs afoul of the ADA.

While the issue has yet to be extensively litigated,[116] as the incentive differential is permitted to increase, so does the likelihood that a court would strike down a program as incompatible with the ADA.[117] It is difficult to characterize a program as *voluntary* when there is a significant financial incentive for participation.[118] The EEOC once promulgated guidance suggesting that a wellness program would be considered voluntary if the inducement did not exceed the 20% limit in HIPAA.[119] This limit was subsequently withdrawn and replaced with the language, "The Commission is continuing to examine what level, if any, of financial inducement to participate in a wellness program would be permissible under the ADA."[120] This shift from a concrete number to a highly subjective standard suggests that potentially *any* financial inducement could be considered a violation of the ADA voluntariness requirement.

113. H.R. REP. NO. 101-485, pt. 2, at 75 (1990) *reprinted in* 1990 U.S.C.C.A.N. 303, 357; EQUAL EMP'T OPPORTUNITY COMM'N, NO. 915-002, ENFORCEMENT GUIDANCE: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS OF EMPLOYEES UNDER THE AMERICANS WITH DISABILITIES ACT (2000), *available at* http://www.eeoc.gov/policy/docs/guidance-inquiries.html.

114. EQUAL EMP'T OPPORTUNITY COMM'N, *supra* note 113.

115. *See supra* Part I.B.2.

116. *But see* Seff v. Broward Cnty., 778 F. Supp. 2d 1370, 1375 (S.D. Fla. 2011) (holding that the county did not violate the ADA by requiring employee medical examinations and asking health related questions of employees as a condition of a wellness program).

117. Mello & Rosenthal, *supra* note 108, at 195; *cf.* Madison et al., *supra* note 5, at 460 n.75 ("The implication is that the EEOC views the provision of benefits as an appropriate baseline, such that a threat to deprive someone of these benefits if they refuse to complete a[] [health risk assessment] has the potential to be coercive, rendering the medical history 'involuntary.'").

118. Madison et al., *supra* note 5, at 460 n.75.

119. JONES ET AL., *supra* note 49, at 8.

120. *Id.*

Opportunities to contest the voluntariness of wellness program participation, and thus challenge program ADA compliance, will increase if Congress or the Secretaries increase the financial incentives to approach the maximum differential.[121] Exactly where a court, an administrative body, or Congress will draw this line remains to be seen.[122] Nonetheless, it is undeniable that there is a significant difference between the old 20% limit under HIPAA, and the 30% (and potentially 50%) limit in the ACA. While the EEOC no longer sets a hard limit, the Commission's continued scrutiny suggests that it considers these programs to be a very real threat to ADA compliance.[123]

2. *Seff v. Broward County* and the Dawn of Wellness Program Litigation

Seff suggests that many employee wellness programs fit nicely within the ADA's safe harbor and are generally consistent with the goals of the ADA.[124] Indeed, most wellness programs are both part of a comprehensive benefits program and are as intuitively beneficial to participants' health. Additionally, most wellness programs use established principles of risk assessment as described in *Seff*[125]: they seek to control risk and cost by making the population healthier.[126] One interpretation of this is that the ADA will not be a major sticking point in determining the legality of wellness programs with financial incentives.[127] But it is also possible that courts will develop a more nuanced approach to evaluating the interplay between the ADA and wellness programs as the number of judicial opinions on point grows.

The only factors the *Seff* court considered when evaluating ADA compliance were: (1) whether the wellness program was a term in a benefit program; and (2) whether it was based on ac-

121. *See* Mello & Rosenthal, *supra* note 108, at 195.

122. *See id.* at 197–98.

123. *Id.*

124. Seff v. Broward Cnty., 778 F. Supp. 2d 1370, 1375 (S.D. Fla. 2011).

125. *Id.* at 1374.

126. *See* Mello & Rosenthal, *supra* note 108, at 192 (noting that a vast majority of employers believe they could reduce their healthcare costs by "influencing their employees to adopt a healthier lifestyle").

127. The ADA's ability to stymie the scope of wellness programs has yet to be determined: the U.S. Equal Employment Opportunity Commission has not taken an official position regarding how the ADA affects wellness programs. *ADA & Gina: Incentives for Workplace Wellness Programs*, U.S. EQUAL EMP'T OPPORTUNITY COMM'N (June 24, 2011), http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html.

cepted risk principles.[128] This analysis forgoes any consideration of voluntariness, whether actual or constructive. The court observed that "in this case, the program was more benign as the employee only faced a $20.00 sanction for non-participation, as opposed to being ineligible for coverage."[129] Perhaps because of the relatively small $20 penalty for non-participation the court in *Seff* assumed voluntariness without explicitly addressing it. The wellness program at issue in *Seff* is further distinguishable from more aggressive programs in that it applied a nominal penalty for non-participants, rather than conditioning a price differential upon the achievement of an outcome.[130] While the holding in *Seff* tentatively bodes well for the legitimacy of wellness programs under the ADA, the case marks only the beginning of wellness program litigation. Much remains to be determined about how more aggressive financially incented wellness programs may be reconciled with the ADA voluntariness requirement.

B. THE ACA AND HIPAA: DIVERGING APPROACHES

By codifying the HIPAA regulations with a greater reward limit, the ACA takes a decidedly different approach to wellness programs. This subsection discusses two important ways wellness programs differ under HIPAA and the ACA. One difference is that by increasing an already generous award maximum, the ACA reflects comfort with increasing the financial incentive. The other difference lies in the Acts' contrasting tones.

While at first glance the difference between a 20% and a 30% reward limit does not appear to be extraordinary, the 50% increase and the high cost of health insurance premiums make this price variation substantial.[131] For example, in 2009, the average premium for one-person employer-sponsored coverage was $4669.[132] Twenty percent of $4669 is $933.80. Thirty percent of $4669 is $1400.70; a 30% limit therefore deprives a ben-

128. *Seff*, 778 F. Supp. 2d at 1373.

129. *Id.* at 1374.

130. *See id.* at 1371–72.

131. *See* Baker, *supra* note 63, at 1603 ("[I]n some cases the rebate could easily exceed the employee's share of the premium.").

132. BETH LEVIN CRIMMEL, AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, MED. EXPEND. PANEL SURVEY, STATISTICAL BRIEF #285, EMPLOYER-SPONSORED SINGLE, EMPLOYEE-PLUS-ONE, AND FAMILY HEALTH INSURANCE COVERAGE SELECTION AND COST, 2009, at 1 (2009), *available at* http://meps.ahrq.gov/data_files/publications/st285/stat285.pdf.

efit recipient of an additional $466 dollars. While the proposed regulations limit the 50% differential to smokers[133]—which is unsurprising both because smoking might be considered more a behavior than a health status factor and because underwriting for smoking has been imagined elsewhere in the ACA[134]—these regulations are only proposed and even if adopted may be amended by the Secretaries. If the Secretaries should permit the maximum 50% limit, a $2334 differential would be permissible in the example above. This is $1401 more than would have been permitted under HIPAA's 20% limit. Exacerbating this result is the fact that premium prices have escalated since 2009.[135] The cost differential today is even greater.

A differential of $933 is far from inconsequential. Even assuming an annual $933 increase is a benign or justifiable differential for individuals failing to achieve certain health status indicators, the difference between $933, $1400, and $2334 respectively is significant. And escalating premium prices magnify these sizable percentage-based rewards.

While the programs may be framed to present these dollar differentials as fair when the money is provided as an extra—a bonus payment for obtaining target health status factors[136]—widespread adoption of large financial "rewards" would ultimately only serve to increase the amount people with poor health statuses pay in relation to people with good health statuses.[137] It is hard to imagine such a differential as a benign bonus.

133. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 Fed. Reg. 70,620, 70,623 (proposed Nov. 26, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–47).

134. *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4004(c)(2)(A), 124 Stat. 545 (2010) (providing for public media campaigns to address smoking cessation); *id.* § 4201(c)(2)(B)(iii), 124 Stat. 565 (creating grants for community smoking cessation programs).

135. *See* Nat'l Bus. Grp. on Health, *Majority of Large Employers Revamping Health Benefit Programs for 2012, National Business Group on Health Survey Finds*, PR NEWSWIRE (Aug. 18, 2011), http://www.prnewswire.com/news-releases/majority-of-large-employers-revamping-health-benefit-programs-for-2012-national-business-group-on-health-survey-finds-128003893.html ("[E]mployers estimate their health care benefit costs will increase an average of 7.2 % in 2012.").

136. *See* Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652, 657 (2008) ("Some plans waive cost-sharing requirements or give 'bonuses' to members who successfully meet health 'goals,' where the goals are risk factors in disguise . . . .").

137. *See* Abigail R. Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209, 2247 (2011).

Even accounting for any decrease in health care costs resulting from healthier outcomes due to program incentives, it would be very expensive for insurers to pay thousands in "bonus" dollars without affecting premiums. Though insurers may try to control costs by providing smaller awards, they may find it more attractive to simply increase the entire group's premium in an amount commensurate with the reward—all individuals in the group would still pay the same premium, but at an inflated price.[138] A policyholder could only decrease his or her health insurance cost to a level at, or below, the actual group risk-rated price by demonstrating healthy health status factors.[139] A cost-conscious insurance plan would likely opt for this latter scenario where it can both cut costs and reap the benefits of a healthier risk pool. Once the dollars at stake become significant—arguably, at the 20% level, as they already are—there is no appreciable difference between financial incentives termed "bonuses" versus "penalties."[140]

Other differences between HIPAA and the ACA create helpful contextual clues useful for understanding how the ACA paints wellness programs in a different light than HIPAA. First and foremost, HIPAA sought to eliminate health status discrimination from group health plans.[141] The exception in HIPAA carved wellness programs out of a general ban on health status discrimination; this exception, however, is strictly controlled through the wellness provision regulations.[142] Abuse

138. *See* Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 221 (2008); Monahan, *supra* note 28, at 325 ("[I]nstead of pooling our collective health risks we are creating ways in which individuals with low health risks can opt out of the risk pool or otherwise receive preferential treatment.").

139. While this design may cause insurers to risk running afoul of their mandatory medical loss ratio, it is nonetheless conceivable that they could strike a balance that results in a premium price that is elevated solely for the reason that discounts are available to people participating in wellness programs and achieving desirable health status factors.

140. *See* Mariner, *supra* note 138, at 221 ("The distinction between rewards and penalties, however, is often in the eye of the beholder.").

141. S. REP. NO. 104-156, at 36 (1996) ("Section 101(a)(1)(A) requires health plan issuers to offer whole group coverage to any group purchaser desiring to purchase coverage. Section 101(a)(1)(B) prohibits employee health benefit plans and health plan issuers offering group health plans from establishing eligibility, continuation of eligibility, enrollment, or premium contribution requirements based on health status, medical conditions, claims experience, receipt of health care, medical history, evidence of insurability, or disability.").

142. *See supra* notes 48–59 and accompanying text.

of financially incented wellness initiatives is prevented by limiting the award for wellness program participation to 20% of an individual's premium cost,[143] along with the other four statutory requirements.[144] Twenty percent was the highest of the proposed percentages under HIPAA[145]: this limit was intended to avoid unduly penalizing people who did not participate or failed to meet a health status standard.[146]

These regulatory provisions are supposed to mitigate the burden of any differential imposed because of an individual's failure to achieve a health status factor.[147] This protective function stands in stark contrast to the ACA's "focus on prevention and wellness."[148] The ACA expressly seeks to expand the role of wellness provisions.[149] It encourages employers to add programs and to experiment with program design to maximize the incentives for health.[150] And so while HIPAA used the wellness program regulations to reign in potentially harmful discriminatory practices, the ACA changes tack, embracing wellness programs and holding them out as a source of innovation to promote healthier living and cost savings.

C. RECONCILING WELLNESS PROGRAMS WITH THE AFFORDABLE CARE ACT

In addition to creating conflict with existing statutes, wellness programs are situated at the juncture of several contradictory policies driving the ACA. This section discusses whether

143. 42 U.S.C. § 300gg-4(j)(3)(B) (Supp. 2012).

144. *Id.* § 300gg-4(j)(3)(C)–(E).

145. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,018 (Dec. 13, 2006).

146. *Id.*

147. *See* Anita K. Chancey, *Getting Healthy: Issues to Consider Before Implementing a Wellness Program*, 2 J. HEALTH & LIFE SCI. L. 73, 85–87 (2009).

148. Peter D. Jacobson & Johanna R. Lauer, *Health Reform 2010: Incremental Advance or Radical Transformation?*, 42 ARIZ. ST. L.J. 1277, 1289 (2011); *see, e.g.*, *Health System Reform: New Health Law Structured to Accelerate Expansion of Wellness, Prevention Programs*, BNA: HEALTH INSURANCE REPORT (Apr. 28, 2010), http://www.lockelord.com/art_bnahealthsystemreform_2010/ ("The recently enacted health care reform law has created unprecedented opportunities for expanding workplace programs for wellness, disease prevention, and chronic disease management . . . ." (quoting health care law attorney Denise Hanna); Majette, *supra* note 45, at 366 (referring to the ACA and "the infrastructure that Congress designed to focus on prevention and wellness.")).

149. *See* 29 C.F.R. § 2590.702 (2012); Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. at 75,018.

150. *See* sources cited *supra* note 149.

wellness programs can accomplish their aim of promoting health and preventing disease in the context of the ACA. This inquiry is complicated by the fact that articulating the precise purpose of the ACA is difficult due to its diverse provisions and the complex health care landscape that the law transforms. This section presents two frameworks useful for considering health policy and analyzes wellness programs using these frameworks.

1. Frameworks for Conceptualizing Wellness Programs

Facially, wellness programs are an interesting experiment in cost control. Practically, however, their presence as an exception to the HIPAA antidiscrimination provisions meshes contradictory policies and creates suboptimal results. Two frameworks for considering health reform that are particularly useful for analyzing the contradictions of wellness programs include: (1) comparing social solidarity and personal responsibility ideologies;[151] and (2) comparing the individualist paradigm and the public health paradigm.[152]

Social solidarity reflects "goals of mutual aid and support."[153] A social solidarity approach to health insurance is characterized by a system where people of all health statuses pay the same for health care coverage.[154] In many ways, group health insurance typifies social solidarity because all employees are offered coverage at the same premium price, even though certain individuals will predictably incur greater health care costs because of their health status, age, or other factor.[155] Personal responsibility reflects that individuals carry different health risks and that individuals are not responsible for the risk of others.[156] An example of personal responsibility is an individual health plan that prices or makes coverage determinations according to the type and amount of risk posed by a particular individual.[157]

151. *See* Mariner, *supra* note 138, at 201–08.

152. *See generally* Micah L. Berman, *A Public Health Perspective on Health Care Reform*, 21 HEALTH MATRIX 353, pt. 1 (2011) (arguing that the ACA reflects an "individualist/biomedical paradigm" of preventive health).

153. Mariner, *supra* note 138, at 205.

154. *Id.* at 206.

155. *Id.* at 207.

156. *Id.*

157. *Id.* at 207–08.

Wellness programs put these two approaches directly at odds. The group insurance setting embodies social solidarity because all individuals in the group pay the same premium. The group's premium is set by the collective risk of the group, thereby assuring everyone coverage even though the premium is more expensive than if the group was composed of a very healthy risk pool. However, wellness programs create a price differential based on a group member's individual health risk.[158] Wellness programs may target factors like blood pressure, weight, and cholesterol level—the very same factors that are used to set premium rates.[159] This creates a scenario where "wellness programs reintroduce the very risk rating that [HIPAA] . . . initially forbade."[160] While this is tempered somewhat by the requirement that wellness programs incorporate alternatives for people unable to meet the standards,[161] the wellness provisions act as a proxy for pricing by underwriting.[162] The overall effect is to introduce stratification into the group market in a way that very much resembles the troubled individual market.[163]

The individualist paradigm and the public health paradigm are useful for exploring another dimension of wellness programs. The individualist paradigm has a biomedical component—the belief that medical research identifies the source and often the solution to health problems—and the idea that an individual is responsible for his or her own health.[164] The public health paradigm takes a "population-based perspective" to health and examines the social and environmental factors that cause variations in health status.[165]

Health promotion and improved health status outcomes are wellness program objectives consistent with the public health model in the abstract. But realistically, wellness programs are more a product of the individualist model.[166] Wellness programs' assumption that an individual's level of motivation is the primary barrier to health and that this motivation

158. *Id.* at 217.
159. *See id.* at 222.
160. *Id.*
161. *See* 42 U.S.C. § 300gg-4(j)(3)(E) (Supp. 2012).
162. *See* Mariner, *supra* note 138, at 222.
163. *Id.* at 225–26.
164. Berman, *supra* note 152, at 356–57.
165. *Id.* at 360–61.
166. *Cf.* Berman, *supra* note 152, at 377 (explaining how the increase in reward limit threatens to worsen workplace inequities).

can be influenced by financial incentives considers almost none of the social and environmental factors that affect health status.[167] A narrow conception of health determinants disparately impacts sub-populations already bearing a disproportionate burden of illness and disease.[168] Wellness programs, as presently described in regulatory and statutory language,[169] are not adequately designed to account for the complexities of health disparities, such as low socioeconomic status.[170] When the most important determinants are excluded from the calculation, the result is to exacerbate disparities rather than improve health.[171] Those individuals "most likely to be subject to wellness program requirements may be those who need insurance the most and can least afford higher costs."[172] This result is neither intended nor desirable.

2. Tension in the Statutory Language

The language in the ACA's wellness program provisions suggests that the aim of the provisions is muddled. If read literally, the statute actually forbids wellness programs from discriminating based on health status.[173] Any wellness plan that conditions rewards on a health status factor must be "reasonably designed to promote health or prevent disease."[174] The statute next lists several tests that such a program must satisfy, including that the program not be "a subterfuge for discriminating based on a health status factor."[175] Given that these wellness provisions exist as an exception to HIPAA's prohibition against health status discrimination, it is facially anomalous that they simultaneously forbid health status discrimina-

167. *See id.* at 377–78; Mariner, *supra* note 138, at 218–25.

168. *See* Berman, *supra* note 152, at 360–61.

169. HIPAA provides an example of a permissible wellness program that conditions rewards on health status factors. This program provides a 20% discount to employees participating in a wellness program that consists of achieving less than 200 mg/dl on cholesterol test (and meets the other statutory requirements for notice and reasonable alternatives). 29 C.F.R. § 2590.702(f)(3) (2012).

170. *See generally* Berman, *supra* note 152 (discussing adequacy of wellness program design).

171. *See id.* at 376.

172. Mariner, *supra* note 138, at 225.

173. *See* 42 U.S.C. § 300gg-4(j)(1)(C), (3)(B) (Supp. 2012) (requiring wellness programs that discriminate "based on a health status factor" not be "a subterfuge for discriminating based on a health status factor").

174. 42 U.S.C. § 300gg-4(j)(3)(B).

175. *Id.*

tion. This textual inconsistency raises more than a minor technical issue, especially considering all of the legal and policy concerns raised by wellness programs that have already been discussed. The confusing language emphasizes that the aim of the statute is not as lucid as it might initially seem.[176] The language appears to give employer health insurance plans permission to develop wellness programs that charge differential prices based on health status factors, while leaving open the possibility for disputes about the legality of such programs.[177] Both incentivizing health and providing affordable insurance coverage for people in poor health are laudable goals, but the wellness provisions' attempt to achieve both at once demonstrates that it is tremendously difficult, if not impossible, for them to coexist in this statute.

D. ADDITIONAL POLICY CONSIDERATIONS

Two additional considerations raised by the current conception of wellness programs are worthy of mention. First, there is a concern that employers will use the programs as an avenue for designing health insurance plans that preferentially select the healthy. Second, wellness programs implicate federal tax policy as it relates to the tax-exempt status of employee health benefits.

When the ACA is fully implemented, employers may use wellness programs as a tool both to indirectly attract healthy employees into their workforce and to push unhealthy employees out of the employer plan and into the state health insurance exchanges.[178] One way to achieve this risk selection is for employers to provide wellness incentives at the maximum allowable financial reward.[179] When it comes to recruiting potential employees, an aggressive wellness program will tend to at-

176. *Cf.* Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 167 (2011) (describing the prohibition of wellness programs that are a subterfuge for discrimination as ineffective and impractical).

177. "Permission" because of the distinction between programs that discriminate on a health status factor, 42 U.S.C. § 300gg-4(j)(B) and (C), as well as an example of a permissible wellness in HIPAA that conditions financial rewards on achieving a desirable cholesterol level. 29 C.F.R. § 2590.702(f)(3) ex. 3 (2012). A "possibility for disputes about the legality of such programs," because the distinction between the aforementioned permissible program that discriminates based upon a health status factor and a program that does not discriminate is unclear from the language in both the ACA and HIPAA.

178. Monahan & Schwarcz, *supra* note 176, at 142–57.

179. *See id.* at 149.

tract the healthy and repel the unhealthy.[180] Also, wellness programs' financial incentives may be used to encourage employees in poor health to seek health insurance in the exchanges rather than through the employer.[181] This effect would be magnified as the differential awarded for a desirable health status increases.

Wellness programs also generate a tax policy consideration arising from the substantial federal tax subsidy received by employer-sponsored health plans.[182] An essential function of employer-sponsored health insurance is to pool risk in a group, making health coverage accessible and affordable to everyone in the group, regardless of health status.[183] While this tax subsidy probably exists more for historic reasons than equitable ones,[184] justification for its continued existence hinges at least in part on the added incentive for employers to offer health benefits.[185] The employer group market is generally considered successful when compared to the individual market because it pools risk and then spreads it evenly.[186] This risk-spreading is most beneficial to individuals likely to have poor health—for instance, persons of lower socioeconomic status.[187] High income individuals, however, are more likely to have tax-exempt group insurance plans.[188] When the group insurance market engages

180. This is a type of "risk classification by design." Risk classification by design refers to the calculated construction of health insurance policies engineered to attract a healthier than average population. *See* Baker, *supra* note 63, at 1589; *see also* Monahan & Schwarcz, *supra* note 176, at 146–47.

181. Wellness programs are just one piece of a complicated incentive structure that an employer may create to encourage employees with poor health statuses to seek health insurance outside of the employer-sponsored program. Monahan & Schwarcz, *supra* note 176, at 158–71.

182. Money paid towards employer sponsored health plans is exempt from income taxation. *See* Goldberg & Camic, *supra* note 34, at 174.

183. Baker, *supra* note 63, at 1595.

184. *See* William P. Kratzke, *Tax Subsidies, Third-Party-Payments, and Cross-Subsidization: America's Distorted Health Care Markets*, 40 U. MEM. L. REV. 279, 285 (2009) (describing the origin of employment-based health insurance as "an historical accident").

185. *See* Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 55 (2010) (describing how tax law augments risk-pooling in group markets).

186. Hoffman, *supra* note 29, at 1884–85.

187. *See* Adler & Newman, *supra* note 105, at 60–61, 70 n.60.

188. J. Paul Singleton, *Can You Really Have Too Much of a Good Thing?: How Benevolent Tax Policies Have Attributed to the Explosion of Health Care Costs and How New Policies Threaten to do More of the Same*, 8 DEPAUL BUS. & COM. L.J. 305, 332 (2010) ("[U]sing pre-tax dollars to save for health insurance is not a benefit for the 36.3% of Americans who, as of 2008, did not owe

in risk stratification, thereby behaving more like the troubled pre-ACA individual market, the equity problem with such a large and unevenly distributed tax subsidy becomes increasingly unjustifiable.[189]

III. BUILDING A BETTER STATUTORY SCHEME FOR WELLNESS PROGRAMS

The implicit message in wellness programs, that people must take responsibility for their own health, may have a prominent role to play in the future of the American health care system,[190] but the legal and policy problems presented by wellness programs raise the question of whether these programs are an appropriate avenue for health promotion and disease prevention. The remainder of this Note suggests that in order to establish clearer and fairer objectives, the wellness program statutory language must be amended to: (1) clarify which types of wellness programs are permissible under the statute; and (2) relax the financial pressure to achieve health status factors.

A. INTERPRETING STATUTORY LANGUAGE

The language in the ACA's wellness provisions should be amended to prevent the law from contradicting itself. As the law is presently formulated, even though wellness programs are designated as an exception to HIPAA's health status anti-discrimination provisions, the wellness provisions themselves prohibit the programs from discrimination based upon health status. This contradiction could be avoided by removing the language, "is not a subterfuge for discriminating based on a health status factor" from 42 U.S.C. § 300gg-4(j)(3)(B) (Supp. 2012). The subsection would then state that a program is rea-

any income tax at the end of the year. Moreover, low-income tax payers are the least likely to be able to afford the rising costs of health insurance. The tax exclusion, then, would provide relatively little benefit to these households even if their marginal tax rate exceeded zero. *Ultimately, this exclusion is little more than a subsidy for the wealthy who receive generous employer-provided health insurance, while those most in need of assistance receive no comparable subsidy through the exclusion*." (emphasis added)).

189. *Cf.* Monahan & Schwarcz, *supra* note 176, at 142 ("In contrast to insurers in the individual market, most employers engaged in relatively little risk classification prior to ACA. For this reason, ACA does little to alter the risk-classification landscape with respect to employers.").

190. For a discussion about the responsibility to be as healthy as you can, see Baker, *supra* note 63, at 1602–06.

sonably designed to promote health or prevent disease "if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and it is not overly burdensome and is not highly suspect in the method chosen to promote health and prevent disease."[191]

This change would certainly not remove all ambiguity but it would eliminate a facial contradiction. A plaintiff challenging the nexus between a wellness program and its reasonable chance of improving participants' health must make a fact-intensive case. This standard sets an especially high bar for the plaintiff because the administrative guidance acknowledges that this nexus does not have to be grounded in sound scientific evidence.[192] Furthermore, it is well within a court's ability and experience to evaluate whether a program is overly burdensome or highly suspect in its method. Under this new construction, a wellness program conditioning financial rewards on health status factors can indisputably qualify for the antidiscrimination exception and be judged to be neither overly burdensome nor highly suspect in its method—a difficult determination under the current statutory language.

It is a trickier piece of statutory interpretation to reconcile the current wellness program exception to HIPAA's antidiscrimination provisions with a prohibition on acting as a subterfuge for discrimination. It is also unnecessary. This prohibition does not add anything to the statute except an inconsistency that could be used to challenge *any* wellness program conditioning rewards on health status factors. Congress did not intend this result as evidenced by the statutory wellness provisions' examples of acceptable programs that condition rewards on health status factors.[193]

Perhaps Congress intended the word *discrimination* to have different meanings in HIPAA and the ACA. It is probably possible to construct a definitional distinction between the use of discrimination in the two contexts. Alternatively, simply eliminating the requirement that a program not be a subterfuge for discrimination would remove this contradiction and allow programs to be developed as Congress intended. Requiring

191. 42 U.S.C. § 300 gg-4(j)(3)(B) (Supp. 2012).

192. *See* Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,018 (Dec. 13, 2006).

193. *See, e.g.*, 29 C.F.R. § 2590.702(f)(3) ex. 3 (2012) (permitting a wellness program that provides a "premium rebate" for participants who obtain a healthy cholesterol level).

a program to not be overly burdensome, or highly suspect in its methods, probably provides a comparable check on overly aggressive wellness programs. Striking this language would make the statute better reflect Congress's purpose and avoid unnecessary litigation over statutory ambiguity. While this textual fix addresses some technical inconsistencies, Congress's conflicted relationship with health status discrimination is indicative of a larger paradox posed by post-ACA wellness programs that is addressed next.

B. THE IMPORTANCE OF EASING THE ECONOMIC PRESSURE OF WELLNESS PROGRAMS

Presently, there are too many incentives for employers to implement wellness programs with an aggressive financial-rewards structure and not enough evidence to support the efficacy of these programs. These incentives could exacerbate health and economic disparities by making health care coverage more expensive for the people who need money and coverage most.

An important counterargument is that this critique of wellness programs assumes that the programs do not actually decrease the cost of health insurance.[194] If the programs are successful then the cost-savings may be passed along to policyholders of all health statuses. If cost-savings via improved health status are both substantial enough and returned to policyholders (as opposed to being absorbed administratively or distributed as profits), then theoretically, everyone in a group health insurance plan could pay enough less that wellness program premium price differentials will function as genuine bonuses. If the programs are truly this effective, people with poor health statuses may benefit from wellness programs despite any differential pricing because of systemically lower health insurance costs. Assuming that wellness programs that account for health status can decrease health insurance premium prices enough to offset any reward, the ACA's support for increased pricing differentials may nonetheless benefit policyholders with poor health statuses.

194. *Cf.* Ezra Klein, *The Promise and Peril of Wellness*, WONKBLOG (Oct. 16, 2011, 9:00 AM), http://www.washingtonpost.com/blogs/wonkblog/post/the-promise-and-peril-of-wellness/2011/08/25/gIQAGzPfkL_blog.html (discussing how spending on employee health care decreased after the implementation of a comprehensive wellness program, including differential premium pricing based upon health status, at the Cleveland Clinic).

To address this counterargument, the effectiveness of financially incented wellness programs must be evaluated. Evaluation considerations include the length of wellness program implementation before evaluation, the demographics of the insured population pre- and post-wellness program, and of course determining the appropriate metrics to measure cost and health status. Alone, these variables are moving targets.[195] It is a daunting task indeed to combine them into an accurate measure of wellness program effectiveness.

This Note does not opine upon the effectiveness of wellness programs beyond making the observation that implementation is in its infancy and program evaluation and comparative effectiveness analysis is far from established.[196] Keeping this in mind, a conservative approach to the creation of programs with financial incentives is warranted. Policymakers should be hesitant to tamper too much with the heavily-subsidized large group insurance market that has been traditionally adept at risk-spreading.

The ACA's increase in permissible financial rewards should be scaled back considering the rapidly rising premium costs and the potential for a difference of thousands of dollars between what healthy and unhealthy group members pay.[197] As premium prices escalate, even HIPAA's 20% cap may be excessive. A 10% to 15% limit would still allow employers to provide hundreds of dollars in savings to incentivize employees to achieve healthier outcomes and be *less* likely to cause excessive financial strain.[198] This precise limit is admittedly somewhat arbitrary, but it better reflects a conservative approach without eliminating the programs entirely. A more stringent limit on the magnitude of incentives decreases the potential for wellness programs to exacerbate existing disparities (albeit, with a corresponding weakened incentive for successful wellness program participation), but still fails to address the problem artic-

195. *See, e.g.*, Katherine Baicker et al., *Workplace Wellness Programs Can Generate Savings*, 29 HEALTH AFF. 1, 2 (2010), *available at* http://content.healthaffairs.org/content/29/2/304.full (describing some of the methodological difficulties in evaluating wellness programs).

196. Madison et al., *supra* note 5, at 453. *See generally* Mariner, *supra* note 13, at 304–05 (explaining some of the methodological challenges in evaluating wellness programs).

197. *See supra* notes 131–35 and accompanying text.

198. Wellness incentives should not impose an "undue burden" under 42 U.S.C. § 300gg-4(j)(3)(A) (Supp. 2012), though no objective measure or further guidance is provided to clarify what this precisely means.

ulated by the public health paradigm: health status is the product of more variables than and individuals' motivation to be healthy.

One alternative to capping the financial incentive at 15% of the premium price would be to require employers with greater financial incentives to participate in pilot programs.[199] Employers using wellness programs with incentives beyond 15% of the purchase price could be required to systematically collect data used to monitor the efficacy of the program over time. These pilot programs could be used to explore and compare the effectiveness of financial rewards of up to 50% of the purchase price. When there is evidence to indicate that programs with greater rewards are effective enough to return net savings to the group, the time will be ripe for broad application of the ACA's wellness provisions.[200] Until then, the best and fairest option when introducing risk stratification into the employer insurance market is the conservative one.

CONCLUSION

At first glance, wellness programs seem like an innocuous and innovative way to incentivize people to improve their health. Upon closer examination, however, the issue is more complex. The manner in which the ACA has structured and promoted these programs creates cause for concern on numerous levels. Wellness programs struggle to marry the competing ideologies of health promotion through financial incentives and expanded and equitable access to affordable health care. The statute's attempt to do so creates a great deal of tension with existing laws and policies both internal and external to the statute. Additionally, the wellness provisions' failure to acknowledge the complexity of health status determinants while increasing the economic pressure to participate in wellness programs is concerning. There is a strong possibility that the ACA's wellness program framework will upset the relative stability of the group insurance market by exacerbating both health and economic disparities rather than improving health and preventing disease. The financial incentives provided by

199. *Cf. id.* § 300gg-4(l)(1) (providing for a ten-state demonstration project piloting wellness programs in state individual markets).

200. *Cf. id.* § 300gg-4(l)(2) (providing for the expansion of the ten-state individual market wellness program demonstration project if the Secretaries of Health and Human Services, the Treasury, and Labor determine that the demonstration project is effective).

wellness program should be reined in, rather than expanded, to prevent burdening the marginalized populations that the ACA is supposed to assist, at least until a more realistic assessment of the actual effect of the widespread implementation of these programs is possible.