

## HEALTH LAW, ETHICS, AND HUMAN RIGHTS

## Wellness Programs and Lifestyle Discrimination — The Legal Limits

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“Personal responsibility” has become a recurrent theme in debates about health care financing.<sup>1</sup> In addition to asking consumers to make better-informed choices in seeking care, many payers are focusing on individual health behaviors as drivers of health spending. In a recent national poll, 91% of employers believed that they could reduce their health care costs by influencing employees to adopt healthier lifestyles.<sup>2</sup>

Many health plans and employers now not only provide access to wellness programs but also offer incentives for participation.<sup>3</sup> Incentives can be framed as rewards or penalties and may take the form of prizes, cash, or the waiver of payment obligations. FedEx, for example, pays \$50 to employees with diabetes who participate in its disease-management program and get both a test for glycated hemoglobin and a retinal examination.<sup>4</sup> More controversially, some employers have begun penalizing employees financially or taking other adverse action on the basis of health risks such as smoking and obesity. In an extreme case, the lawn care company Scotts Miracle-Gro fired an employee on the basis of the results of a drug test that detected tobacco use.<sup>5</sup>

The ethical issues surrounding wellness incentive programs have stirred considerable discussion,<sup>6,7</sup> but the legal dimensions are not well understood. In this article, we examine the extent to which employers and health plans can provide rewards or otherwise adjust individual health insurance costs based on the steps employees or plan members take to reduce their health risk.

### GROWING INTEREST IN WELLNESS PROGRAMS

Although wellness programs have long been present in the workplace, there is renewed interest among employers and insurers in deploying them to control the cost of health benefits.<sup>3</sup> In 2006,

19% of employers with 500 or more employees offered workers incentives to complete a health-risk appraisal, demonstrate good health behavior, or participate in a risk-reduction program; only 7% of companies of this size did so in 2004.<sup>8</sup> The use of premium differentials as incentives further increased among large employers from 2006 to 2007.<sup>3,9</sup> Nearly 40% of all employers reported in 2007 that they would pay employees for health-enhancing behaviors in the next 2 to 3 years.<sup>2</sup> Similarly, 40% supported higher insurance premiums for obese persons who declined to participate in weight-management programs, and 37% supported the idea of requiring such participation as a condition of group health coverage.<sup>2</sup>

Wellness incentives also enjoy widespread support among insurers. In 2007, 66% of insurers reported being somewhat or very likely to provide “carrots” for health-enhancing behaviors, and 44% said they would probably charge higher premiums for members with characteristics that put their health at risk.<sup>2</sup> Two thirds of these insurers supported the idea of charging higher premiums for obese persons who would not participate in weight-management programs and 58% supported the idea of requiring participation as a condition of coverage.<sup>2</sup> A number of major health insurers have already launched rewards programs. For example, Blue Cross–Blue Shield of Michigan created both health maintenance and preferred-provider plans that give employees discounts of up to 20% on copayments and deductibles and that offer employer and employee premium discounts if employees agree to “adopt a healthy lifestyle” (which may include enrolling in a smoking-cessation program or weight-loss program), to complete a health-risk appraisal, and to have their doctor verify their compliance with their health-promotion plan every year.<sup>10,11</sup>

A welter of state and federal laws and regula-

tions intersect to determine the legal permissibility of wellness incentive programs. Here we analyze the most important legal provisions, including the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and offer some recommendations and reflections on program design.

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#### THE LEGAL BOUNDARIES: FEDERAL LAW

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##### HIPAA NONDISCRIMINATION RULES

For incentive programs operated by insurers, the most important applicable legal provisions are the nondiscrimination provisions of HIPAA.<sup>12</sup> In December 2006, the Departments of Labor, Treasury, and Health and Human Services issued final rules clarifying the applicability of the nondiscrimination provisions to wellness programs that offer financial rewards.<sup>13</sup> These rules, which implement amendments to the Internal Revenue Code, the Employee Retirement Income Security Act (ERISA) of 1974, and the Public Health Service Act, apply to group health plans and issuers of group health insurance, except for some small plans. The rules do not apply to employers *per se*. HIPAA's nondiscrimination provisions generally bar group health plans and insurers in the group market from discriminating on the basis of a health factor, but the final rules set out certain exceptions, including wellness programs that satisfy certain criteria.

The general rule under HIPAA is that no person can be denied group health insurance or charged more for coverage than other "similarly situated" persons because of health status, genetic history, evidence of insurability, disability, or claims experience.<sup>14</sup> The phrase "similarly situated" refers to an employment-based classification, such as full-time or part-time, not a classification based on health factors.

HIPAA does allow health plans to exercise discretion in ways that implicate health conditions. They can charge one group health plan more than another because the members of the group are sicker. They can require current and potential members to complete a health-risk appraisal or medical questionnaire, as long as they do not use the information to restrict eligibility or benefits or determine premiums. Health plans can also restrict or opt not to provide coverage for particular health conditions if the limit applies to all similarly situated persons and is not adopted in

order to avoid a particular person's claim. Finally, with some limitations, they may practice "benign discrimination" — discrimination in favor of people who have an adverse health factor. For example, they can waive the deductibles of people with diabetes who enroll in a health-management program.<sup>15</sup>

The wellness-program provisions supplement this list by describing allowable uses of financial incentives in wellness programs. These provisions apply when a group health plan offers an incentive that affects the plan's benefit design or cost for the participant (again, they do not affect incentives offered by employers that do not relate to health plans, such as giving employees a cash bonus for attending a weight-management program). The incentive could take the form of a premium discount or rebate, a full or partial waiver of cost-sharing mechanisms (deductibles, copayments, or coinsurance), the waiver of a surcharge, or the value of a benefit that would otherwise not be provided under the plan, such as prizes.<sup>13</sup>

HIPAA makes it easy for health plans to reward members for participating in health-promotion programs but difficult to reward them for achieving a particular health standard. The rules divide wellness programs into two categories.

In the first category are programs in which rewards are based solely on program participation. Examples given in the final rules include reimbursing enrollees for the cost of gym memberships, rewarding enrollees who undergo diagnostic testing (regardless of the outcome of the test), waiving copayments for prenatal care, and reimbursing enrollees for the cost of smoking-cessation programs (regardless of whether they successfully quit smoking).<sup>13</sup> Programs in this category are automatically permissible.

Programs in the second category are those in which rewards are based on the attainment of a certain health standard — for example, achieving a targeted cholesterol level, maintaining a certain body-mass index, stopping smoking, or losing a specified amount of weight. Health plans can offer such financial incentives only if five criteria are met (Table 1), the most important of these being that the reward is limited to less than 20% of the cost of the employee's coverage (i.e., the employee's premium plus the employer's contribution) and that if it is "unreasonably difficult" or "medically inadvisable" for a person to satisfy the health standard owing to "a medical condition," that per-

**Table 1. HIPAA Nondiscrimination Rules for Group Health Plan Wellness Programs.**

| Program Type  | Example   | Permissibility under HIPAA  |
|---|---|---|
| Plan members are rewarded for participating in health-promotion programs or pursuing health-related goals, but not for obtaining or maintaining a certain health standard | Reduced copayments for smokers who complete a smoking-cessation program, even if they do not quit smoking         | Clearly permitted   |
| Program costs and benefits are based on members' individual health factors, regardless of whether they participate in wellness programs                                   | Upward premium adjustment for all persons with a body-mass index >30*   | Clearly prohibited  |
| Plan members are rewarded upon attainment of a health standard in a wellness program  | Deductible waiver for persons who maintain a certain blood glucose level as part of a diabetes-management program | Permitted only if the following five criteria are met:<br>Reward is limited to 20% of the cost of the member's coverage†<br>Wellness program is reasonably designed to promote health or prevent disease<br>Members can try to obtain the reward at least once a year<br>Reward is available to all "similarly situated" persons; if a medical condition makes it inadvisable or impossible to meet the standard, the member can meet a reasonable alternative standard‡<br>Availability of a reasonable alternative standard is disclosed in program materials |

\* Body-mass index is the weight in kilograms divided by the square of the height in meters.

† The cost of coverage includes both the employer and employee contributions. If dependents are participating in the wellness program, the applicable amount is the cost of the employee's coverage plus the dependents' coverage.

‡ The phrase "similarly situated" refers to an employment-based classification, such as full-time or part-time, not a classification based on health factors.

son must be offered a reasonable alternative standard. No definition of "medical condition" is provided, but one example given is that of a smoker for whom it is unreasonably difficult to quit smoking owing to "an addiction to nicotine (a medical condition)."<sup>13</sup> The plan must disclose the availability of an alternative standard in wellness-program materials. It is unclear whether obesity would be considered a medical condition that makes it unreasonably difficult to achieve a weight goal, but a reasonable inference from other examples given in the rules is that morbid obesity could well be considered as such.

#### AMERICANS WITH DISABILITIES ACT

Title I of the Americans with Disabilities Act (ADA) of 1990 prohibits private employers with 15 or more employees, state and local governments, employment agencies, and labor unions from discriminating against persons with a "disability" in hiring, firing, advancement, compensation, training, and other terms, conditions, and privileges

of employment, including health insurance benefits.<sup>16,17</sup> Employers must make "reasonable accommodations" for otherwise qualified workers with disabilities.<sup>18</sup> Similar protections apply to federal employees and federally funded programs through section 501 of the Rehabilitation Act of 1973.<sup>19</sup> The ADA's nondiscrimination provisions apply to wellness programs offered by employers even if those programs do not involve a group health plan, and they cover employer actions that target employees' health, such as administering a health-risk questionnaire, even if that action is not part of a formal wellness program.<sup>15</sup>

Title III of the ADA provides for equal access to public accommodations, including insurance. Some courts have construed this provision as prohibiting disability discrimination in the provision of insurance.<sup>20</sup> However, a special "safe harbor" applies to health insurers' pricing decisions. A health insurer may make disability-based distinctions in eligibility, benefits, and costs among enrollees if the distinction is "based on sound

actuarial principles or is related to actual or reasonably anticipated experience.<sup>221-23</sup> In other words, insurers can discriminate on the basis of a health factor if they can show that the health factor increases a person's risk of incurring medical expenses.

The ADA's protections extend only to health conditions that meet the statutory definition of a "disability," which is a physical or mental impairment that substantially limits one or more major life activities even when the person is using a mitigating measure (such as medication or eyeglasses); a history of such an impairment; or being regarded as having such an impairment.<sup>24</sup> According to this definition, nicotine addiction is not considered a disability.<sup>25</sup>

Obesity presents a more complex issue. Some courts have found morbid obesity (but not moderate overweight) to be an "impairment" when the evidence establishes a "physiological cause."<sup>26</sup> For example, one employee was deemed disabled because her morbid obesity was caused by a "dysfunction of both the metabolic system and the neurological appetite-suppressing signal system."<sup>27</sup> The Equal Employment Opportunity Commission has taken the position that morbid obesity always qualifies as an impairment under the ADA, but courts appear to favor the distinction between physiological and nonphysiological, despite its murkiness. Thus, even if the safe harbor does not apply, plaintiffs will probably have difficulty prevailing in claims that insurance discrimination against overweight and obese persons violates the ADA.

The ADA has three implications for wellness programs. First, insurer-based programs that involve higher costs or more restricted eligibility or benefits for persons with health problems than for healthier individuals must be able to establish that the distinction has an actuarial justification. Second, wellness programs will encounter legal difficulty if they withhold employment-related rewards from employees, or impose costs or penalties on them, on the basis of a "disability" or the failure to meet a health standard that a disability makes it difficult to meet. Finally, the ADA limits an employer's ability to collect employee health information, as in health-risk appraisals. Title I prohibits employers from making health inquiries or requiring medical examinations unless they are "job-related and consistent with business necessity."<sup>28</sup> Thus, employers generally may

not require employees to complete health-risk questionnaires that ask about disabilities. Asking about lifestyle factors that may be indicative of disabilities may be legally treacherous as well.

However, employers may request medical examinations that are not job related and may elicit medical histories, including questions about disabilities, as part of a voluntary wellness program if three requirements are met: participation in the program is voluntary, the information is not used to discriminate against an employee, and the information is treated as a confidential medical record separate from personnel files and is accessible only to wellness-program personnel.<sup>23</sup> The larger the financial incentive to complete a health-risk appraisal, the more likely it is that a court will view the wellness program as not truly voluntary, particularly if the incentive looks more like a penalty than a reward.<sup>29</sup>

#### OTHER APPLICABLE LAWS

A smattering of other federal statutes have bearing on the operation of incentive programs. ERISA, which covers employee benefit plans, sets forth fiduciary obligations for fair program administration and standards for information disclosure, claims and appeals procedures, and remedies for wrongful denial of benefits. It prohibits arbitrariness in program administration and requires that incentive programs be explained to insured persons in a comprehensible way.<sup>30</sup>

Federal civil rights laws, including the Civil Rights Act of 1964, the Equal Pay Act of 1963, and the Age Discrimination in Employment Act of 1967, require employers to offer the same benefits, incentives, and programs to employees of different races, national origins, religions, sexes, and ages. The Equal Protection Clause of the U.S. Constitution prohibits invidious discrimination on the basis of these and other traits by government agencies and actors. Wellness programs must design incentives in such a way that they do not run afoul of these provisions. The Pregnancy Discrimination Act of 1978 makes it particularly important for incentive-program sponsors to provide a reasonable alternative for women whose pregnancy makes it medically inadvisable for them to meet a specified health standard.<sup>31</sup>

Incentive programs through which employers contribute money to health savings accounts or flexible spending accounts may have implications for the federal tax code. Except in the context of

“cafeteria plans,” employers who opt for such programs must make comparable contributions to the accounts of all eligible employees or risk a tax penalty.<sup>32</sup> Contributing only to the accounts of employees who participate in wellness programs would violate this “comparability rule.”<sup>33</sup> In addition, if financial incentives for participation in wellness programs are treated as income under the tax code,<sup>31</sup> the effectiveness of the incentive may be limited unless the employer offsets the additional tax liability. Finally, wellness programs may have implications for the National Labor Relations Act of 1935. A labor union may claim that a wellness program is among the terms and conditions of employment that the union and the employer have agreed to negotiate, on the basis of the provisions of a collective bargaining agreement.<sup>34</sup>

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#### RELEVANT PROVISIONS OF STATE LAWS

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##### ANTIDISCRIMINATION LAWS

About two thirds of the states have adopted laws that prohibit employers from discriminating against employees on the basis of certain kinds of conduct when not on the job. All such laws bar discrimination on the basis of tobacco use, and a minority extends protection to use of other lawful products.<sup>35</sup> These laws target employers, not insurers, but many are worded broadly enough to cover employer discrimination in the provision and terms of insurance and other fringe benefits. Only a small number explicitly allow employers to charge workers different prices for insurance if it is related to actuarial risk.

Nearly all states have disability discrimination laws as well, some of which define “disability” more broadly than their federal counterparts.<sup>36</sup> Some state courts, for instance, have found obese persons to be disabled within the meaning of state antidiscrimination statutes.<sup>37,38</sup> One state, Michigan, explicitly prohibits discrimination in employment and public accommodations on the basis of weight.<sup>39</sup> Two California cities, Santa Cruz and San Francisco, do the same, with the latter exempting police officers, firefighters, and the 49ers football team.<sup>40</sup>

States may also have laws specifically prohibiting insurance discrimination based on health factors or laws stating more generally that insurance eligibility can be conditioned only on the basis of employment classifications. A few such laws

effectively bar the use of financial incentives for participation in a wellness program, although most do not.<sup>15</sup>

The relationship between state laws involving insurance, health plans that are regulated by ERISA, and the HIPAA nondiscrimination provisions is complex. Ordinarily, ERISA preempts state insurance laws insofar as they are applied to employer-sponsored group health plans, but there are many exceptions. The amendments to ERISA passed as part of HIPAA further muddied the waters by altering the usual rules. However, state weight- and insurance-discrimination laws are likely to be preempted to the extent that they obstruct the implementation of wellness programs that are permitted under HIPAA. Nevertheless, the ambiguity that exists about this, and the fact that non-ERISA plans will remain subject to the state insurance laws, suggest that wellness-program sponsors should pay careful attention to state law.

##### STATUTES SUPPORTIVE OF WELLNESS PROGRAMS

A number of states have adopted statutes to encourage the growth of employer- and insurer-based wellness programs.<sup>41</sup> For example, Michigan recently amended its insurance code to allow insurers to offer premium or cost-sharing rebates of up to 10% to participants in wellness programs offered by employers or insurers.<sup>42</sup> Vermont allows discounts of up to 15% for participants in “health promotion and disease prevention” programs.<sup>43</sup> Florida requires insurers to rebate up to 10% of premiums to employers if a majority of health plan enrollees participate in a wellness program.<sup>44</sup> There is uncertainty about whether a state may choose to allow larger financial incentives than the HIPAA regulations allow (e.g., a 30% rebate). ERISA probably preempts such laws when they are applied to employer-sponsored group health plans, but this is not entirely clear.

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#### DISCUSSION

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##### THE LEGAL LIMITS OF INCENTIVE PROGRAMS

Several rules of thumb and recommendations for wellness-program design and administration emerge from analysis of applicable law (Table 2).<sup>34</sup> The most important of these can be distilled into an overarching litmus test of program legality: health plan sponsors of wellness programs cannot “pay for performance” — they can pay only

**Table 2. Recommendations for the Design of Legally Compliant Wellness Incentive Programs.\***

|   |
|---|
| Document program goals and the reasons why medical inquiries are needed to achieve them and why the program is a reasonable means of achieving them.  |
| Limit incentives to modest rewards that are activity-based, not achievement-based.  |
| Provide accommodations and reasonable alternative standards for persons with disabilities or health conditions.   |
| Make detailed, comprehensible information about the program available to potential participants, including procedures for obtaining an accommodation or alternative standard and for challenging decisions made by the program. |
| Retain a third party to manage medical information and maintain a firewall between that information and the employer.   |
| Emphasize the voluntary nature of participation.  |

\* Adapted from Alvarez and Soltis.<sup>34</sup>

for participation. That is, they may not make the achievement of a health standard the basis of an incentive, only the willingness to try to achieve it. Employers offering wellness incentives that are separate from their health plans have a bit more latitude but are still constrained by the ADA.

Although the recently issued guidance resolved many questions about the legal boundaries of incentive programs, some ambiguities remain, creating potential risk for program designers. Confusion stems, in part, from the interplay of federal and state laws that govern insurance plans: the contours of ERISA preemption are still opaque in some areas. In addition, there is little case law or other experience to suggest how the courts might interpret language such as “voluntary” in the context of substantial bonuses or penalties with regard to participation in wellness programs, or what constitutes a “medical condition” that makes attainment of a designated health standard “unreasonably difficult.”

#### THE FUTURE

There is every reason to expect that over time employers and health plans will become more involved in encouraging behaviors that reduce health risks. Such programs can be implemented without violating the law if designed carefully. It remains to be seen, however, whether programs designed to stay within the boundaries of the law can be effective in reducing health risks and health care costs.

One key question is how large an incentive is needed to gain widespread participation in wellness programs. In general, people are more likely to change their behavior if the stakes are higher

(i.e., large cash awards or coverage contingencies), although larger rewards may also encourage cheating.<sup>45</sup> Programs that offer only modest rewards may appeal primarily to people who do not have to make radical lifestyle changes to satisfy the reward criteria — in other words, those who already practice healthy habits.

The size of the incentive required may vary depending on the behavior change sought. Employees who are asked to make large lifestyle changes may demand commensurate compensation. On the other hand, employees may prove willing to participate in wellness programs with modest incentives because they share the goal of reducing their health risks and appreciate the availability of a structured means of doing so.<sup>45</sup>

Although the law limits the size of incentives that may be offered, sponsors may be able to gain traction by framing wellness incentives as penalties rather than rewards. A strand of economic theory — and some empirical evidence — suggests that negative incentives have a more powerful effect on behavior than positive ones.<sup>46-48</sup> Thus, describing a 20% cost-sharing difference as a surcharge rather than a discount may command greater attention.

A second tension arising from legal constraints on wellness incentives concerns the question of whether providing an alternative health standard for people who will have difficulty achieving the target standard would compromise a program's power to induce behavior change in those who have the most to gain. Theory suggests that rewards contingent on attainment of a goal rather than mere participation are more likely to produce results.<sup>49</sup> Indeed, the final HIPAA rules ex-

PLICITLY acknowledge that the use of alternative standards could undermine the effectiveness of incentives for wellness.

A third question is whether wellness programs that adhere to a purely or predominantly “pay for participation” model will provide their sponsors with a sufficient return on investment. Of particular interest is whether the lifestyle changes and health-risk reductions that wellness programs inspire are sustained over time. Behavioral science literature suggests that although incentives may induce behavior change in the short term, in some cases they may also dampen intrinsic motivation, with negative long-term consequences for behavior.<sup>50,51</sup> Finally, it remains to be seen whether the cost savings associated with healthier behaviors accrue to the employers and insurers that encouraged those changes or arise down the road, benefiting other payers.

Some health plans may offer wellness programs and incentives primarily to increase their marketing appeal and build customer loyalty, and some employers may be interested mainly in promoting workplace satisfaction. Others, however, seek to reduce costs. Despite the substantial attention that wellness programs have attracted, the conditions required for achieving this objective remain murky. Program design will need to evolve as systematic program evaluations improve knowledge about what is effective. Adaptations in the regulatory regime will also be needed to encourage best practices as they emerge.

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