Wellness Incentive Programs

The Patient Protection and Affordable Care Act (PPACA) includes significant changes to the rules governing wellness programs. These changes include provisions that would allow employers and health insurance companies to potentially discriminate against individuals who fail to achieve health related targets.

Background

Current Law

For many years, employers have implemented wellness programs for their employees to encourage a healthy and productive workforce. In many cases, these wellness programs provide positive opportunities for employees to improve their fitness, nutrition, and make other life changes to help them get and stay healthy. For example, health promotion activities such as making exercise equipment available at the worksite, allowing flex-time for walking or other physical activity, and offering smoking cessation and nutrition education classes have encouraged employees to engage in valuable wellness activities.

In recent years many employers have experimented with programs that tie financial incentives to employees' participation in wellness programs or achievement of a certain health status standard. These incentives can include providing discounts on health insurance premiums, deductibles, or other forms of cost sharing.

While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally prohibits group health plans from charging employees different premiums based on their health status, it allows employers to establish premium discounts or provide other financial incentives for employees who participate in health promotion programs or achieve certain health targets.[1] Later regulation distinguished between programs that simply require employees to participate in a program and those that require employees to meet certain health status standards.[2] "Participation only" programs do not have to meet additional requirements, but programs that are "standard-based" have to meet five additional benchmarks:

- The reward for the program can't exceed 20% of the cost of employee-only coverage under the plan;
- The program must be "reasonably designed" to promote health or prevent disease;
- The program must give employees the opportunity to qualify for the reward at least once per year;
- The reward must be available to all employees, and a "reasonable alternative standard" must be available to any individual for whom it is unreasonably difficult to meet the standard due to a medical condition, or for whom is "medically inadvisable" to attempt to meet the standard;
- The plan must disclose in its written materials that a reasonable alternative standard is available.[3]

1 42 U.S.C. 300-gg-1(b)(2)(B).
2 45 CFR § 146.121.
3 26 CFR § 54.9801-1(f)(2)(ii); 29 CFR § 2590.702(f)(2)(ii); 45 CFR § 146.121(f)(2)(ii).

Examples of "participation-based" wellness programs:

- Incentives to participate in a health fair
- Waiver of co-payment/deductible for well-baby visits
- Reimbursement for gym membership
- Reimbursement for smoking cessation programs (regardless of outcome)

Examples of "standards-based" wellness programs:

- Providing a premium discount to employees who have an annual cholesterol test and achieve cholesterol levels below 200.
- Waiving the annual deductible for employees who have a body mass index (BMI) within a specified range.
- Imposing a surcharge on employees who don't provide an annual certification that they have not used tobacco products within the last 12 months.

These programs must also comply with the federal Americans with Disabilities Act (ADA), which prohibits employers from discriminating against disabled individuals, and limits the circumstances under which employers can require medical examinations or responses to medical inquiries.[4] Employers must also comply with the Genetic Information Non-Discrimination Act (GINA), which limits their ability to ask employees questions about family history on health risk assessments.[5]

Expansion of Law under PPACA

Beginning in 2014, PPACA expands HIPAA's wellness program exemption to allow employers to offer employees incentives of up to 30%, and could be expanded to 50% (if the Secretaries of Labor, Health and Human Services, and Treasury approved) of the cost of their coverage for meeting employer-defined health targets.[6] Incentives could be in the form of premium discounts, waivers of cost-sharing requirements or the absence of a premium surcharge. Further, the law requires a 10-state demonstration project to extend wellness incentive programs to the individual insurance market where there is no employee/employer relationship.[7]

The Secretaries of Labor, HHS, and Treasury must submit a report to Congress within 3 years of the law's enactment evaluating:

- The effectiveness of the wellness programs in promoting health and preventing disease;
- The impact of wellness programs on access to care and the affordability of coverage; and
- The impact of premium-based and cost-sharing incentives on behavior.[8]

4 42 U.S.C. § 12101 et. seq.
5 Under GINA, family history is considered genetic information because it is often used to determine whether someone has an increased risk of getting a disease, disorder, or condition in the future. See 42 U.S.C. § 2000ff(4).
6 PPACA § 1201, adding new Public Health Service Act (PHSA) § 2705(j).
7 § 2705(l).
8 § 2705(m).

Issues to Consider

Discrimination based on health status

The law allows any premium discounts for healthy individuals to be financed through penalties or surcharges on those who are less healthy. This is in direct opposition to other provisions of PPACA that expressly prohibit setting premium rates based on health status. And in the individual market demonstration projects, where there is no employer to sponsor workplace wellness programs, the initiative is likely to be little more than bare premium adjustments based on health status, which would be indistinguishable from medical underwriting.

The law allows employees and individuals to ask for a waiver from the program, if they can show that they have a medical condition that makes it unreasonably difficult or inadvisable to attempt to meet the standard. However, the law allows employers to require verification of the employee's condition, which raises significant concerns about the privacy of that information. In addition, people who face barriers to participation for non-medical reasons, such as a second job or family responsibilities, are not allowed to receive a waiver.

The premium surcharges for individuals who cannot meet the health targets set by their employer could be steep. The law allows for "incentives" up to 50% of the cost of coverage paid by the employer and employee. The table below shows the average costs of coverage in 2009 and the amount of the discount or penalty that could be charged for individuals and families.

HIPAA Premium Variation Under 20%, 30%, and 50% Scenarios

	Total Cost of Employer-Sponsored Coverage	Amount of Incentive or Penalty		
		20%	30%	50%
Individual	$4,824	$965	$1,447	$2,412
Family	$13,375	$2,675	$4,013	$6,688

Source: Average premiums as paid by employer and employee for family coverage in 2009 based on Kaiser/HRET annual survey of health plans.

Current law allows insurance costs to vary for employees by up to 20% — or $2,675 based on average family coverage. PPACA takes that percentage up to 30% — or $4,012 for average family coverage, and potentially up to 50%, which would total $6,688 for an average family.

These significant cost differentials could lead to adverse risk selection, allowing employers to effectively force less healthy employees out of their risk pool by making coverage unaffordable for them. This may reduce costs for employers, but would likely increase premium costs for the government and other individuals who purchase through the new insurance exchanges.

Further, these programs will make the cost of insurance much higher for the very people who

need health care services the most. Research has shown that people with conditions like cancer, diabetes and heart disease are much less able to treat and manage their condition when their insurance costs are too high.[9,10]

Impact on vulnerable populations

Women, low-income, and minority individuals are at a disadvantage when employers tie the cost of insurance to the ability to meet certain health targets. These populations are more likely to have the health conditions wellness programs target and face more barriers to healthy living.[11,12] These barriers may be work related, including higher levels of job stress, job insecurity, long working hours, and second or third jobs. Or, just as likely, the barriers are outside of work, rooted in employees' daily lives, including caregiving responsibilities, unsafe neighborhoods, lack of access to healthy foods, or financial burdens.[13]

Privacy implications

Many wellness programs require the individual and in some cases family members to complete a "health risk assessment" or be interviewed by a health coach employed by the health insurer or a third party health wellness company. Often these surveys or interviews solicit personal health information. Many employees understandably prefer to keep this type of information private out of concern they may be treated differently in the workplace, or potentially deprived of promotions or other opportunities for advancement.

Employers are generally not covered by the federal privacy law that limits access to and use of personal health information. If an employer uses a health insurance company to administer the wellness program and collect employees' responses to health assessments, then those companies are subject to federal privacy law and must limit the employers' access to the information. But if the employer collects the information themselves, or contracts with a disease management company to do so, there may not be any rules governing who can access that data and how it can be used.

Lack of evidence

Studies to evaluate the use of financial incentives to change employees' behaviors are inconclusive. Some studies have shown that some financial incentives can help employees meet certain

9 Rice, T. and Matsuoka, K. "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors." Medical Care Research & Review 61:4 (2004): 415-452.

10 Solanki G., Schauffler H.H., Miler L.S. The direct and indirect effects of cost-sharing on the use of preventive services. Health Serv Res. 2000 February; 34(6): 1331-1350.

11 Salganicoff, A. et al., "Women and Health Care: A National Profile," Kaiser Family Foundation, July 2005. Accessed at http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf.

12 Liburd L., Giles W., Mensah G., "Looking through a glass, darkly: eliminating health disparities." Preventing Chronic Disease. 2006 Jul;3(3):A72. E-publication accessed at http://www.cdc.gov/pcd/issues/2006/jul/pdf/05_0209.pdf.

13 Thompson S.E., Smith B.A., Bybee R.F.. Factors influencing participation in worksite wellness programs among minority and underserved populations. Fam Community Health. 2005;28(3):267-273.

wellness goals.[14,15,16] However, these studies are often limited by small numbers of participants and lack of long term data.17 And none of the studies involved premium discounts or surcharges in employer-sponsored health care programs.

For those types of programs, there is simply no authoritative research on whether or not they work.[18]

For example, a premium incentive program that has received a lot of attention from politicians and the media for reportedly reducing the company's health care costs — the Safeway Healthy Measures initiative — has only been in place since 2009, not long enough to evaluate the impact on employees or health spending.[19]

Conclusion

PPACA's provisions that allow for premium surcharges or cost-sharing increases for people who cannot meet certain health standards are an unproven, and likely counter-productive approach to improving health outcomes or decreasing health costs. They could result in making insurance unaffordable for individuals with chronic conditions, the very people who need access to health care the most. They could also become a significant loophole from the law's provisions that bar plans from charging people more based on their health status.

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15 Volpp K.G., Pauly M.V., Loewenstein G., Bangsberg D. P4P4P: an agenda for research on pay-for-performance for patients. Health Aff (Millwood). 2009;28(1):206-214.

16 Finkelstein E.A., Linnan L.A., Tate D.F., Birken B.E.. A pilot study testing the effect of different levels of financial incentives on weight loss among overweight employees. J Occup Environ med. 2007;49(9):981-989.

17 Hey K., Perera R. Competitions and incentives for smoking cessation. Cochrane Database Syst Rev. 005(2):CD004307.

18 Bensinger G. "Corporate Wellness, Safeway Style". San Francisco Chronicle. Jan. 4, 2009.

19 Hilzenrath D. "A success story that isn't shapes health-care debate; Blood tests and weigh-ins Misleading claims drive 'Safeway Amendment.'" *Washington Post*. Jan. 17, 2010.