Premium Incentives to Drive Wellness in the Workplace:

A Review of the Issues and Recommendations for Policymakers

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Executive Summary

Employers are increasingly turning to workplace wellness initiatives to curb rising health care costs and the growing prevalence of chronic conditions. Workplace wellness programs can take many different forms, from on-site flu shots and smoking cessation programs to programs that impose significant financial penalties on employees who do not participate or fail to meet health goals, such as employer-defined Body Mass Index, cholesterol, blood glucose or blood pressure levels. Recent changes enacted in the Affordable Care Act (ACA) allow employers to link greater financial incentives to the achievement of these and other clinical targets.

While wellness programs, if properly designed, hold the potential to improve health and encourage healthier behaviors, there is also limited evidence of what works. If poorly designed, workplace wellness programs can shift costs to those with the greatest health care needs; run afoul of federal anti-discrimination and privacy laws and the ACA's prohibition on health status rating; and potentially affect which workers remain in employer plans and which end up in the new health insurance exchanges, possibly with a federal subsidy.

As more and more employers implement wellness incentive programs for their workers, it will be important to establish standards at the state and federal level for consumer protections to guard against those programs that inappropriately punish workers in poor health, are overly coercive, or create perverse financial incentives that result in poorer health outcomes. It is unclear how many wellness programs link financial incentives to health outcomes, but regulators should require these workplace wellness programs to include:

- Health benefits that help pay for any required services such as nutrition counseling and disease management for targeted health conditions such as diabetes;
- Multi-pronged programs that go beyond tying premiums to biometric measures and include support for improving behavior and health outcomes;
- A reasonable time for participants to meet program goals, with incentives to make progress toward those goals;
- Protections to ensure workers' premiums are not rendered unaffordable because they cannot satisfy the employer's health targets;
- Safeguards to ensure such programs do not serve as a subterfuge for health status discrimination or result in adverse selection against insurance exchanges; and
- Requirements for employers and vendors to report on incentives and other program elements, in order to identify best practices and any adverse consequences for employees.

Introduction

Employers are increasingly turning to workplace wellness initiatives to curb rising health care costs and the growing prevalence of chronic conditions.[1] Since the roughly 150 million workers with employer sponsored insurance[2] spend a significant share of their waking hours at work, promoting prevention and wellness initiatives at the workplace can be an effective approach. Studies estimate the return on investment for workplace wellness programs is between $3 to $6 in savings for every $1 invested, generally after two or more years of implementation. These savings result from lower use of health care services, reduced absenteeism and reduced workers compensation and disability claims.[3]

Workplace wellness programs can take many different forms, from programs that promote participation in wellness activities, such as on-site flu shots, health fairs, employee assistance programs and smoking cessation programs, to programs that impose significant financial penalties on employees who do not participate or fail to meet health goals, such as employer-defined Body Mass Index (BMI), cholesterol, blood glucose or blood pressure levels. Recent changes enacted in the Affordable Care Act (ACA) give employers the ability to raise the amount of financial incentives that are linked to the achievement of these and other clinical targets.

At the same time, one of the most highly touted and significant reforms in the ACA is the ban on health plans' ability to charge higher premiums based on an individual's health status. This reform, coupled with the law's efforts to make health coverage more affordable through premium and tax subsidies for individuals and small businesses, is essential to the law's larger goal of making health coverage more accessible. Although workplace wellness programs encompass a broad range of activities and program design, this paper focuses on a subset of workplace wellness programs –those that link an employee's ability to achieve health targets to the amount he or she pays for health care – that could undermine that goal and make health coverage less affordable for some workers, simply because of their health status. We thus provide some recommendations for state and federal policymakers to provide consumer protections that will guard against possible discrimination based on a worker's health status.

Examples of Workplace Wellness Programs Outside the Scope of Federal Law

- On site flu shots
- Redesigned cafeteria with nutritional content for meals
- Lunchtime walking program

Examples of Workplace Wellness Programs Under the Scope of Federal Law

- Reduced deductible for taking a Health Risk Assessment
- Reduced cost-sharing for participation in chronic care management program
- Increased premiums for a BMI that exceeds 29

Federal Rules Governing Workplace Wellness Programs

Under federal law, employers have broad flexibility to implement a workplace wellness program if it is completely independent of the health plan they offer to workers. However, if their wellness program operates as a component of the employer-sponsored health plan, it must comply with certain federal rules barring workplace discrimination. 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, but it includes an exception to this prohibition to allow employers to provide financial incentives for employees who achieve certain health goals or participate in certain health promotion programs.[4] Federal regulations published in 2006 distinguish between wellness programs that simply require employees to *participate* in a program and those that require employees to achieve certain health status standards.[5] Programs that tie financial incentives to "participation only" do not have to meet additional requirements, but programs that are "standard-based" have to meet five benchmarks:

- The reward for the program can't exceed 20% of the cost of employee-only coverage under the plan or 20% of the cost of family coverage if the program applies to dependents;
- 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;
- All employees must have the opportunity to gain the reward, and if an employee has a medical condition that would make it "unreasonably difficult" to meet the standard, the employer must offer a "reasonable alternative standard"; and
- The plan must disclose in its written materials that this reasonable alternative standard is available.[6]

Under the rule, "reasonably designed" means that the program must have a reasonable chance of improving the health of or preventing disease in participating individuals and is not overly burdensome, is not a "subterfuge for discrimination" based on a health factor, and is not "highly suspect" in the method chosen to promote health or prevent disease.[7]

Employers are increasingly implementing workplace wellness programs, but most simply provide financial incentives for participation in health promotion activities, such as smoking cessation and weight management programs, completion of health risk assessments (HRAs) and increased physical activity and exercise. However, the 2006 regulation explicitly allows employers to use premium penalties for workers who don't meet health standards to fund premium discounts for those who do. A "standard-based" wellness program may become more attractive to employers seeking to cut costs, but it increases the risk that wellness programs will result in higher premiums or cost-sharing for workers based solely on their health status.

Believing these incentive programs could help constrain the growth of their health care costs, many employer groups successfully lobbied for a provision in the ACA that expands HIPAA's wellness exemption.[8] Beginning in 2014, employers may offer employees incentives of up to 30% of the cost of their coverage, if they meet employer-defined health targets. And the Administration may, by regulation, expand the financial incentives to 50% of the premiums, if the Secretaries of the Departments of Labor, Health and Human Services, and the Treasury approve. Employers can offer premium discounts, lower deductibles and waivers of cost-sharing requirements for employees who do well or, conversely, higher premiums, deductibles, or other forms of higher cost-sharing for employees who don't meet the employer's goals. The Department of Labor (DOL) announced in December 2010 that the Department of Health and Human Services, the Treasury Department and DOL intend to use existing authority under HIPAA to raise the percentage for the maximum reward to 30 percent prior to 2014 and indicated that they are considering "consumer protections that may be needed to prevent the program from being used as a subterfuge for discrimination based on health status."

State Rules Governing Workplace Wellness Programs

In our review of state rules on workplace wellness programs, we found two types of state action. Several states – including New Hampshire,[10] Rhode Island[11] and Michigan[12] – have passed legislation promoting the use of wellness products through discounts, preferred rates, or rebates to employers that purchase the products. These state laws may include general requirements for what constitutes a wellness product, such as the promotion of primary and preventive care and care coordination for people with chronic health conditions. Other states – including New York[13], Wisconsin[14], Alaska[15], and Georgia[16] – have adopted legislation providing safe harbor protections from state discrimination or unfair trade practice statutes to any workplace wellness program that conforms to federal HIPAA regulations.

States also have the opportunity to require consumer protections that exceed those under the federal rules. For example, Colorado has enacted legislation allowing premium incentives based on attainment of standards, with protections and provisions that go beyond federal law. The state first enacted legislation (HB 09-1012) that allowed insurance carriers in the individual and small group markets to provide premium and other financial incentives for participation in wellness programs. One year later, the statute was modified by a new law, HB 10-1160, to allow incentives for participation or "based upon satisfaction of a standard related to a health risk factor."[18] Although the Colorado provisions largely track the federal rule, the 2010 legislation included important consumer protections that exceed those under the federal rule. In particular, it

requires wellness programs to be accredited by a nationally recognized non-profit organization that accredits wellness programs, prohibits penalties for non-participation or failure to satisfy a standard, and allows individuals to request an independent external review if the carrier denies a request for an alternative standard or waiver of a standard.[19]

In addition, the law requires the Colorado Division of Insurance to report to the Legislature annually (until 2015) on the types of wellness programs and the nature of incentives offered in the individual, small group and large group markets. The report is based only on 2010 data and reports only on the data collection outlined in the statute, which doesn't include a comparison of programs that focus on participation in wellness programs rather than meeting a health status standard. However, the Division's first report is an important first step in understanding the extent and type of wellness programs operating in the state.

The Division found that about one third of carriers in the individual, small group and large group markets offered wellness programs in 2010. Of those carriers offering wellness programs, 43% of those in the individual market had participants, and about three quarters of carriers in the small group and large group markets had participants.[20] Although financial incentives for wellness programs in the small group and individual markets were the focus of the legislative initiative, no carriers in those markets reported spending on financial incentives.

The Division must review and approve all health insurance rate increases before they are used, and their review takes into consideration the structure and costs of wellness programs offered by carriers. Enforcement of the specific consumer protections is largely left to responding to consumer complaints and inquiries, due to resource constraints. The Division received no complaints about wellness programs in 2010.[21] However, the Division will integrate compliance with wellness program rules into their current market conduct exam process.[22]

Other states are considering similar action. For example, in 2011, the California legislature considered a small group market reform bill that included workplace wellness provisions (2011 California Assembly Bill No. 1083). The legislation would have allowed workplace wellness programs to tie premium incentives to participation in wellness programs while prohibiting incentives for meeting a biometric or health status standard. During consideration of the bill, consumer advocates sought additional protections, including a prohibition on premium incentives increasing the cost of coverage to more than the federal definition of affordable coverage under the ACA (9.5% of household income). Although the legislature ultimately failed to pass this bill, it is expected to resume the debate over workforce wellness programs by considering similar legislation in 2012.

Policy Considerations

While wellness programs, if properly designed, hold the potential to improve health and encourage healthier behaviors, there is also limited evidence of what works. If poorly designed, workplace wellness programs can shift costs to those with the greatest health care needs, run afoul of federal anti-discrimination and privacy laws and the ACA's prohibition on health status rating, and affect which workers remain in employer plans and which end up in the new health insurance exchanges, possibly with a federal subsidy.

Lack of evidence

Employer surveys indicate growing interest in using financial incentives in their workplace wellness programs. While most programs target participation (e.g., programs offering cash incentives for completing an HRA grew from 35% to 63% between 2009 and 2010),[23] a small but growing number of programs are designed to target specific biometric outcomes (e.g., programs targeting weight control or cholesterol levels grew from 6% to 13% between 2009 and 2010) and even more plan to use standard-based programs in 2012.[24] However, studies suggest that financial rewards worth more than $450 have little additional effect on rates of participation in wellness programs,[25] and according to surveys, the average employee incentive is between $300 and $430 – nowhere near the 20% limit now allowed.[26]

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 wellness goals.[27] However, these studies are often limited by small numbers of participants and lack of long term data.[28] And none of the studies involved premium or cost-sharing discounts or surcharges in employer-sponsored health care programs, which would directly affect the cost of obtaining coverage or care for certain workers. For those types of programs, there is simply no authoritative research on whether or not they work.[29] For example, a premium incentive program that has received attention from politicians and the media – the Safeway Healthy Measures initiative – has only been in place since 2009 and there is no published data about its effectiveness. The grocery store chain also implemented a range of cost containment strategies at around the same time, and it is difficult to ascertain whether the program's reported cost savings and employee health outcomes can be attributed to the financial incentives or to these other cost containment strategies.

Impact on vulnerable populations

There is little data on the prevalence of programs such as the example given below, which may be both rare and extreme. But this type of program may be appealing to employers seeking to constrain their own rapidly increasing health insurance costs and provide an affordable benefit to their employees. However, whether by design, as in the product that promotes the savings associated with shifting costs to "higher utilizers" of health care services, or in practice, programs linking premiums and cost-sharing to health status will make the cost of insurance much higher for the very people who need health care services the most. These higher costs can have significant implications for employees' ability to manage chronic conditions and can result in adverse health outcomes. 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 high.[30],[31]

Additionally, women, low-income, and minority individuals can be 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 that wellness programs target and face more barriers to healthy living.[32],[33] These barriers may be work related, including higher levels of job stress, job insecurity, long working hours, and second or third

Measure Up or Pay Up

One workplace wellness vendor, for example, offers employers a wellness program that links incentives to targeted biometrics. While marketed to employees as a rewards program for those who succeed in meeting the health targets, in practice, this program uses higher deductibles to penalize those who fail. For example, the vendor offers a supplemental policy that allows workers to "buy down" a high deductible by achieving specified biometric targets. In an example provided on the vendor's website, an employer would first increase the health plan deductible from $500 to $2,500, then offer employees a wellness policy that lets them "earn credits" of $500 each by "demonstrating appropriate body mass, blood pressure, and cholesterol levels, as well as non-tobacco use" based on the results of a medical screening. Employees that hit all four targets will earn back the original plan deductible of $500; those who don't will pay more. In its advertising, the vendor made the following marketing claims about the benefits of its program for employers.

The Marketing Claims of One Wellness Vendor

Employers will realize immediate savings in the following ways:

- 12 – 18% net savings realized (includes cost of program)
- Specific/aggregate premium reductions
- ***Unearned credits shift claims cost to higher utilizers of the plan***
- ***Employees with few credits may be motivated to consider other coverage options***
- Increase return on investment on Disease and Large Case Management due to early notification
- 90% participation in voluntary wellness screenings, including a blood draw
- Critical notifications to employees of potential serious conditions (emphasis added)

jobs. Or, just as likely, the barriers are outside of work, rooted in employees' daily lives, including care giving responsibilities, unsafe neighborhoods, lack of access to healthy foods, or inability to pay for gym memberships or the costs of wellness programs.[34] These are also the very people who will likely be the most sensitive to even small cost-sharing changes in their health benefits, and the most likely to forego necessary care because of a co-payment or deductible.

Privacy implications

Many wellness programs require the individual and in some cases family members to complete a HRA or be interviewed by a health coach employed by the health insurer or a third party wellness program vendor. Often these surveys or interviews solicit personal health information. Many employees may 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.

Programs that collect this data can use it in aggregate and with personal, identifying information removed. Otherwise, HIPAA's privacy regulations, which limit access to and use of personal health information, may apply. While health plans are subject to privacy protections restricting the release of personal medical information, some employers and non-medical companies that offer questionnaires and screening may not be.

Interaction with federal anti-discrimination laws

Wellness programs, if poorly designed, may violate federal anti-discrimination laws other than HIPAA. The Americans with Disability Act (ADA) requires any medical exams and inquiries to be voluntary and the information gained must be kept confidential and not used to discriminate. Employers can only require employees to provide personal health information if they can demonstrate that there is a "business necessity" for them to have it. The Equal Employment and Opportunity Commission (EEOC) is looking at "what level, if any, of financial inducement to participate in a wellness program would be permissible under the ADA"[35] and has indicated that "a wellness program is 'voluntary' as long as an employer neither requires participation nor penalizes employees who do not participate."[36] Such an interpretation suggests that a wellness program that would raise employees' premiums or cost-sharing if they fail to participate may then be in violation of the law. However, to date, neither the EEOC nor the Department of Labor has provided any clear guidance on this issue.

Another federal law, the Genetic Information Non-discrimination Act (GINA) protects against employers requiring or even providing financial incentives for workers to provide genetic information, which is defined in GINA to include any request for an employee's family history.[37] Yet many HRAs administered as part of a wellness program have included questions about family history.[38] In addition, the Age Discrimination in Employment Act (ADEA) prohibits employment discrimination against individuals over the age of 40. If a wellness program has a disparate impact on older workers, which can occur if wellness programs target chronic conditions that may be correlated with age, the program may violate ADEA. Finally, Title VII of the Civil Rights Act of 1964 prohibits discrimination based on an individual's race, color, religion, sex or national origin. Any wellness program that has a disparate impact on these protected classes could violate this statute.

Implications for Affordability of Coverage and Insurance Exchanges

The ACA includes several provisions that ensure coverage is affordable for individuals, whether enrolled in an employer plan or covered through an exchange. Workers whose employer-sponsored coverage costs them more than 9.5% of household income qualify for subsidized coverage through an insurance exchange. Federal subsidies help defray premium and cost-sharing expenses on a sliding-scale, based on family income. And individuals can be exempt from the individual requirement to purchase coverage if the cost of coverage would exceed 8% of household income.

At the same time, wellness incentive programs that impose premium surcharges on employees can have significant financial implications. The average cost of employer-sponsored family coverage in 2011 was $15,073.[39] Under current law, an employer could add $3,015, or 20% of the total cost of the premium to the employee's premium payment for a family policy. If, as contemplated by the ACA, the amount at risk rises to 50% of the premium, the employee could be charged an extra $7,536 for coverage, an amount that, for many

families, may mean that their employer's plan is simply no longer affordable to them. See Table 1.

It is currently unclear whether the penalties an employee might pay as a result of a wellness incentive program would be counted for purposes of considering whether a worker's insurance is "affordable" under the ACA and whether he or she would be eligible for subsidized coverage through an exchange. The Administration will need to clarify this through rulemaking. If the regulations do not include the wellness premium penalties in the affordability calculation, depending on the size of the penalty, some workers may find coverage unaffordable. On the other hand, if the penalties are included in the affordability calculation, employers may have an incentive to use wellness programs to drive more costly employees into the exchange for coverage, leaving comparatively healthy employees to remain in the employer's risk pool. Such perverse incentives, if acted upon, would undermine the long-term sustainability of the risk pool within insurance exchanges.

Table 1: Premium Variation Under 20%, 30%, and 50% Scenarios

	Average total Cost of Employer-Sponsored Coverage	Amount of Incentive or Penalty		
		20%	30%	50%
Individual	$5,429	$1,086	$1,629	$2,714
Family	$15,073	$3,015	$4,522	$7,536

Source: Average premiums as paid by employer and employee for family coverage in 2011 based on Kaiser/HRET annual survey of health plans.

One Person's Plight: A Wellness Program That Doesn't Work

A workplace wellness program offered at a large physician-owned health care system in Wisconsin requires workers to pay higher premiums if they do not participate in the program or cannot meet the program's identified goals. One worker, T.K., has been unable to meet the standard and has seen her family's premium increase from $175 per month to $320 per month. T.K. suffers from Type I diabetes, and although she passed all five fitness tests given to participants, T.K. did not meet the target Body Mass Index (BMI) of 24. She was exempt from meeting the target when she was pregnant. After her baby's birth, her doctor still advised her not to try to meet the program's weight loss goal because she was breastfeeding and regularly experiences low blood sugar episodes (hypoglycemia).

While the employer reduced T.K.'s weight loss goal, her doctor continued to advise that any weight loss was medically inadvisable for her while she was trying to manage her diabetes and continue breastfeeding. In spite of this recommendation, her employer refused to exempt her from the BMI target and required her to comply with an alternative: to work with a trainer at the company gym for 130 minutes per week. However, T.K. was required to pay out-of-pocket for these sessions, a financial burden not faced by other program participants. She was also required to participate in the training sessions outside of working hours, in spite of her need to breastfeed and care for her new baby.

We have no data to determine how prevalent a program like this may be, but it illustrates a number of challenges – and needed consumer protections – for workplace wellness programs. First, the program does not appear to be "reasonably designed to promote health." Premiums are linked only to attainment of the target BMI and the program doesn't credit T.K. for the fitness tests, her exercise at home, or her doctor's advice. Second, T.K. had both medical and non-medical reasons that made attainment of the standard "unreasonably difficult," but her employer recognized only her medical reason. Even then, the alternative standard offered to her was unworkable and costly. Despite T.K.'s efforts to participate in the program within her doctor's guidance and her personal constraints, her family is paying substantially more for their insurance, making this program more about punishment for failing to meet a standard than promoting a positive health outcome.

Recommendations

As more and more employers implement wellness programs for their workers, we can expect the number of programs that tie financial incentives to achieving a health outcome will also grow. For premium-incentive programs, it will be important to establish consumer protections to guard against those programs that inappropriately punish workers in poor health, are overly coercive, or create perverse financial incentives that result in poorer health outcomes or destabilize state insurance exchanges. This is particularly critical because there is limited evidence that financial penalties tied to health-status targets result in improved employee health.

There are opportunities at both the federal and state level to adopt additional consumer protections. The Departments of Labor, Health and Human Services, and Treasury are considering such consumer protections and have indicated they may issue a rule amending the existing HIPAA framework to raise the allowable financial incentives to 30% prior to 2014. In addition, any consumer protections established under federal law would set just a minimum standard. States can enact legislation to further protect consumers covered in state-regulated markets. In fact, in the absence of additional federal protections, states have an incentive to adopt rules that protect against workplace wellness programs that prompt the least healthy employees to seek subsidized coverage in the exchange.

Implement Wellness Incentive Rules Based on Evidence of What Works

The Administration may, with a regulatory change, allow employers to increase financial incentives in wellness programs in advance of 2014, when incentives would automatically increase to 30% of premiums under the ACA, and to increase that to 50% with approval of the secretaries. But there is little evidence or market research that would demonstrate a need to do so. In fact, survey data suggest that the majority of employers provide small financial incentives, nowhere near the 20% of premium now allowed.

At a minimum, the Administration should assess whether there is a sufficient policy rationale for advancing the implementation of increased financial incentives in workplace wellness programs. As noted above, there is simply no authoritative research on whether or not these types of programs actually improve health outcomes or save money over the long term. If the Administration decides to implement the ACA provision before 2014, it will need to incorporate additional protections for employees, such as those described below.

Provide Greater Consumer Protections

Business representatives note that employers are pursuing wellness programs because they want a healthier, more productive work force. They have little desire to reduce morale through programs that could be perceived as punitive or coercive.[40] And, as noted above, existing law requires wellness incentive programs to have a reasonable chance of improving health or preventing disease, and they cannot be a subterfuge for health status discrimination. However, employers face strong pressure to lower the costs of providing health insurance coverage, and such pressures could lead some to embrace wellness incentive programs that reduce the likelihood sicker employees will take up or maintain their employer-sponsored health plan.[41]

Unfortunately, the current HIPAA rules do not take into account the strong evidence that the most effective programs are those that reduce barriers and provide the supports needed for employees to change their behavior.[42] Where wellness programs use increased financial penalties to change behavior and lower health costs, the rules should be amended to require that the health plan cover the services employees will need to attain health goals, such as nutrition counseling and disease management for targeted health conditions such as diabetes.[43] The rules should also include program elements to protect consumers, such as clear disclosure of program requirements, an option to anonymously provide feedback, and due process for employees who cannot meet a program-required health standard.[44] There are additional challenges for wellness programs that tie financial incentives to family premiums, since family members are harder to reach with workplace-based programs. Employers that do so should be required to develop programs that provide an equal level of support for spouses and dependents to help them participate and meet any defined biometric or behavioral goals.

Not only should wellness incentive programs provide the necessary institutional supports to help people meet the desired health outcomes, federal and state policymakers should make clear that a program that doesn't have those supports cannot demonstrate a "reasonable chance of improving the health of or preventing disease," a required benchmark under HIPAA.

Similarly, when a wellness incentive program increases health insurance costs for certain employees to the extent that they must seek alternative coverage through insurance exchanges, the Administration should make clear it will be viewed as a "subterfuge for discrimination based on a health factor" unless the employer can show that its program has positive effects on health outcomes.

Programs should also give participants a reasonable period of time to achieve designated goals or make progress toward achieving those goals, taking into account the individual's health and their doctor's guidance. For some individuals, because of genetics, age, or other factors unrelated to motivation or willpower, achieving specific health targets may be difficult or even impossible to meet. Programs that take an "all or nothing" approach to meeting health targets or apply a single, fixed target to all employees should be considered suspect under federal anti-discrimination rules.

The current HIPAA rules require program materials to disclose the availability of reasonable alternative standards, specifically noting that employees may access alternatives for medical reasons. However, as noted above, some barriers to achieving a standard may not be medical in nature. The rules should therefore specifically allow employees to provide non-medical reasons for accessing an alternative standard, such as additional jobs, care-giving responsibilities, unsafe neighborhoods, and lack of access to healthy food. And because families' circumstances can change at any point in time, the alternative standard should be available at any point in the plan year (not just annually).

The current rules are also silent on whether merely making an alternative standard available is sufficient to satisfy the "reasonably designed" standard. Therefore, the Administration should amend the HIPAA rules to make clear that alternative standards must include access to programs that are reasonably designed to promote wellness, including the financial and other supports needed to use the program. It should not be sufficient to assign an alternative standard without making available an affordable, reasonably designed program to help the participant achieve that alternative standard. For example, employees that have to pay significantly more out of pocket to access an alternative standard are at a disadvantage and such an "alternative" should not be allowed to satisfy the HIPAA benchmark.

As federal and state policymakers consider additional consumer protections, it is entirely appropriate for them to consider whether they may individually or cumulatively affect innovation in an emerging field or place undue burden on employers seeking to constrain costs. But where the potential exists for negative consequences for employees' ability to access needed care or pay premiums, protections are not only appropriate but necessary.

Protecting Access to Affordable Coverage

The ACA provides subsidies for individuals who are under 400% of the federal poverty level and whose offer of employer coverage would require them to pay premiums that exceed 9.5% of their household income. Because penalties as high as 30% or 50% of the cost of coverage can quickly render the cost of insurance unaffordable to workers, particularly low- and middle-income workers, the Administration should require such penalties to be counted toward total premium for purposes of measuring affordability and establishing eligibility for an exemption from the individual mandate or for subsidized coverage through an exchange.

Promoting Evidence-Based Programs and the Diffusion of Best Practices

Finally, the federal and state rules should promote evidence-based innovation in workplace wellness by providing an opportunity to learn from new models. Programs should be required to report on the amount, timing and duration of any incentives used, key program elements, and the effect on health outcomes for workers, in order to identify both best practices and unworkable programs that need to be either improved or terminated.

The ACA promotes wellness and prevention and protects against discrimination based on health status. Workplace wellness rules must ensure programs that use financial penalties comport with both components of the law.

Endnotes

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