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The Affordable Care Act: Discouraging or Promoting Wellness?

By
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Employee wellness programs have arguably been around for 15 or 20 years. However, in the past five years these programs, which seek to promote a healthy lifestyle, maintain or improve health and/or prevent the onset of disease, have come increasingly more prominent in the American workforce. Only recently wellness programs have gained traction in the corporate world, and because of that, there has been little to no clear rules surrounding these programs. The Health Insurance Portability and Accountability Act (HIPAA), since its original publication, has included a clause prohibiting discrimination due to a health factor.[1] In 2006, the Departments of Health and Human Services, Labor and the Treasury (collectively the "Departments") proposed, finalized and published rules in the Federal Register in an effort to provide guidance around the HIPAA wellness provision.[2] Yet it wasn't until The Affordable Care Act (ACA) wellness provisions came into effect January 1, 2014 that wellness and its regulations were brought to the forefront of the public's attention. In November of 2012, the Departments jointly proposed rules on wellness programs to reflect the changes to existing wellness provisions made by the Affordable Care Act and to encourage appropriately designed, consumer-protective wellness programs in group health coverage. These rules were finalized and entered into the Federal Register on June 3, 2013 and effectively amended the previous wellness rules.[3]

The ACA wellness provisions set out to clarify and more specifically regulate what it means to be a wellness program, the correct use of incentives within a corporate wellness program and steps to ensure no employee is discriminated against when participating in such a program. In reviewing these rules, various commentators inferred the strict rules of the ACA would prohibit employers from seeing real results in their wellness program and diminish the meaning of the incentives provided. However, at further review, the ACA has done just the opposite. The ACA has taken a substantial step in achieving the goals of the Departments, by effectively regulating wellness programs to better promote people of all health and wellness levels to achieve their goals and improve their health.[4] This article will dive deeper into the claims of critics of the ACA wellness provisions and highlight the benefits these regulations are having in the wellness space, as well as discuss additional next steps the Department should take to continue to work toward their goals of improving wellness.

The Original Regulations: HIPAA and Other Wellness Rules

HIPAA, enacted in 1996, was aimed to improve the portability and transparency of health coverage. HIPAA, among other things, generally prohibits group health plans from discriminating against individual participants and beneficiaries in eligibility, benefits or premiums based on a health factor.[5] As an

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[1] Health Insurance Portability and Accountability Act of 1996, 110 Stat. 1936, P.L. 104-191 (1996).

[2] Federal Register (2006), Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, Final Rule.

[3] Federal Register (2012). Incentives for Nondiscriminatory Wellness Programs in Group Health Plans. 71 FR 75014.Washington, D.C. Proposed Rule: 77 FR 70620–70642 *compared to* Federal Register (2013). Incentives for Nondiscriminatory Wellness Programs in Group Health Plans. Washington, D.C.: Final Rule [contemporaneously published].

[4] *See* Department of Labor. Fact Sheet: The Affordable Care Act and Wellness Programs. (Accessed March 2014 http://www.dol.gov/ebsa/newsroom/fswellnessprogram.html). "Implementing and expanding employer wellness programs may offer our nation the opportunity to not only improve the health of Americans. . .The Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. . . and to encourage appropriately designed, consumer-protective wellness programs in group health coverage." *Id.*

[5] The HIPAA nondiscrimination provisions set forth eight health status-related factors, which the December 13, 2006 final regulations refer to as "health factors." Under HIPAA and the 2006 regulations, the eight health factors are health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. *See* 66 FR 1379, January 8, 2001.

exception to this general rule, HIPAA does allow for premium discounts or rebates or modification to otherwise applicable cost sharing (copayments, deductibles or coinsurance) in return for adherence to certain programs of health promotion and disease prevention. As HIPAA itself was broad and undescriptive, the Departments published both interim rules as they relate to individuals whose health coverage was affected by any health factor in 2001 as well final rules in 2006. These rules created some clarity around wellness by dividing wellness programs into two categories, participatory and health contingent.[6] The 2006 final rules provided substantial groundwork for future legislatures to adapt and build as wellness adapted, leaving many rules broad and up to interpretation until more regulations were required.[7] This next step did not occur until recently when the Departments, as part of the Affordable Care Act, revised their previous rules and took a big step in shaping wellness as it should be.

The Affordable Care Act: Wellness Regulations

In the 17 years since HIPAA, including the nondiscrimination piece regarding wellness, was published, the wellness space has greatly evolved. In light of the expansion of wellness throughout the country, the Departments sought to address pending and future concerns through the ACA. The ACA regulations stand behind the principal that an appropriately-designed and regulated wellness program has the potential to contribute to promoting health and preventing disease. The ACA regulations sought to clarify and refine the scope of the wellness regulations promulgated pursuant to HIPAA and its rules governing wellness programs. The final regulations set forth criteria for a wellness program that must be satisfied in order to qualify as meeting the wellness non-discrimination exception to HIPAA.[8] By enhancing these explanations and regulations, these concepts have been brought to the forefront of wellness.

The ACA regulations went further to differentiate health contingent programs into activity- or outcome-based subcategories, resulting in three types of wellness programs, Participatory, Activity-Based and Outcome-Based.[9] The average wellness program will be distinctly one of these types. Certain programs are unique as they may incorporate elements of all three types in one comprehensive program. Participation, activity and outcomes are important for sustained employee engagement and employee health.

What are the three types of programs?

Participatory wellness programs are programs that either do not provide a reward or do not include any conditions for obtaining a reward that are based on an individual satisfying a standard that is related to a health factor, for example a program that provides a reward for participating in a biometric screening and does not base any of the reward on outcomes achieved.[10] So long as a participatory

[6] Under the 2006 regulations, a participatory wellness program is generally a program under which none of the conditions for obtaining a reward is based on an individual satisfying a standard related to a health factor or under which no reward is offered. Comparatively, a health-contingent wellness program is generally a program under which any of the conditions for obtaining a reward is based on an individual satisfying a standard related to a health factor (such as not smoking, attaining certain results on biometric screenings, or meeting targets for exercise).

[7] The preamble to the 2006 regulations stated that the "reasonably designed" standard was designed to prevent abuse, but otherwise was "intended to be an easy standard to satisfy . . . There does not need to be a scientific record that the method promotes wellness to satisfy this standard. The standard is intended to allow experimentation in diverse ways of promoting wellness." *See* 71 FR at 75018. The preamble also stated that the Departments did not "want plans and issuers to be constrained by a narrow range of programs . . . but want plans and issuers to feel free to consider innovative programs for motivating individuals to make efforts to improve their health." *See* 71 FR at 75019.

[8] As the regulations outline the requirements for groups to satisfy an exception, these rules are creating the guidelines for satisfying an *affirmative defense* to use to respond to a claim that the plan discriminated under the HIPAA nondiscrimination provisions.

[9] 78 FR. 33158 (2013).

[10] Examples include (1) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment (2) a program that provides a reward to employees for attending a monthly, no-cost health education seminar, or (3) a program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking.

wellness program is provided to all similarly situated individuals, it is not required to satisfy any other standards.

Alternatively, the ACA also describes a health-contingent program, which is a program that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward).[11] A health-contingent wellness program may be an activity-only wellness program or an outcome-based wellness program.

Activity-only wellness programs, one of the subcategories of a health-contingent wellness program, require an individual to perform or complete an activity related to a health factor in order to obtain a reward or avoid a penalty, such as taking 10,000 steps per day or maintaining a minimum heart rate for more than 30 minutes. However, the activity-only wellness programs do not require an individual to attain nor maintain a specific health outcome. The regulations provide safeguards to ensure individuals who may be unable to participate in or complete the activity due to a health factor are given a reasonable opportunity to qualify for the reward or avoid the penalty. Comparatively, in outcome-based wellness programs, another subcategory of health-contingent wellness programs, an individual must attain or maintain a specific health outcome in order to obtain a reward or avoid a penalty. For instance, having a BMI of less than 25 or being a non-smoker. The regulations provide safeguards to ensure individuals who may be unable to achieve or maintain a specific health outcome due to a health factor are given a reasonable opportunity to qualify for the reward or avoid the penalty.

How are the programs regulated?

As participatory programs have either no conditions for obtaining a reward that are based on a standard related to a health factor or no offered reward, they must comply with only two simple requirements: (1) the programs must be offered to all similarly situated individuals and (2) the individuals eligible for the program must be given the opportunity to qualify for the incentive at least once per plan year. In other words, if a company wants to offer an incentive for simply completing a health risk assessment or for "knowing your numbers" by getting a full biometric screening, it may do this with no limitation as to number of programs or type of programs offered. The company's only responsibility is to ensure that it offers such a program in a manner which is compliant with the definition of "similarly situated individuals."[12]

Wellness programs based on a person's health status, or health-contingent programs, however, are only allowed so long as the following five requirements are followed, each of which is discussed more fully in the following sections:

1) The individuals eligible for the program must be given the opportunity to qualify for the incentive at least once per plan year.
2) The total incentive offered to an individual cannot exceed thirty percent (30%) of the total cost of employee only coverage under the plan.[13]
3) The incentive must be available to all similarly situated individuals, including providing

[11] Examples include (1) A program that provides a reward to employees who are non-smokers or (2) a program that provides a reward to employees who have a BMI under a certain level.

[12] 78 FR. 33158 para (f)(2) (2013). If a plan made available a premium discount in return for attendance at an educational seminar, but only healthy individuals were provided the opportunity to attend, the program would discriminate based on a health factor because only healthy individuals were provided the opportunity to reduce their premiums. However, if all similarly situated individuals were permitted to attend, but a particular individual could not attend because the seminar was held on a weekend day and the individual was unavailable to attend at that time, that does not mean the program discriminated against that individual based on a health factor. Because there is no discrimination based on a health factor under HIPAA, the wellness exception is not relevant. At the same time, compliance with the HIPAA nondiscrimination and wellness provisions is not determinative of compliance with any other applicable Federal or State law, which may impose additional accessibility standards for wellness programs.

[13] If dependents are part of the plan, plans and issuers have flexibility to determine apportionment of the reward among family members so long as the method is reasonable. In addition, should a group choose to utilize a tobacco outcome incentive, the reward may be up to 50% of the total cost of health care.

a different, reasonable means for qualifying for the incentive, or reasonable alternative standard.

4) All plan materials describing the program terms and the incentives available must disclose the availability of the selected and compliant reasonable alternative standard.[14]

5) The program must be reasonably designed to promote health or prevent disease.[15]

While many of these requirements are not wholly new in the world of wellness, the ACA has clarified what they mean and the standards to satisfy them. Utilizing the five factors mentioned above, the ACA seeks to ensure that all individuals of all health levels have access to the same benefits, regardless of any accommodation they may need, and that the program is administered in a way that displays a reasonable design to promote health and/or prevent disease.

Health Contingent Programs Requirement One: Qualify Once Per Year

For the purposes of this discussion, this first requirement is not a "hot topic." All people under a plan must have the opportunity to receive the reward offered by an employer once per health plan year. This requirement particularly comes into play for those employees that are either new hires in the middle of the year or who due to a life event join the plan after its effective date. While simple, this rule ensures all members of a group, regardless of enrollment date, have the opportunity for a benefit. It is not a new rule or requirement but rather just repeated and maintained from the original HIPAA-based rules.[16]

Health Contingent Program Requirement Two: Maximum Incentive Value

Unlike the first requirement, the maximum incentive value as described in the ACA varies from the previous HIPAA-based rules. Specifically, the ACA mandates the total reward offered to an individual under all health-contingent wellness programs with respect to a plan cannot exceed the applicable percentages of either 30% or 50% of the total cost of employee-only coverage under the plan, taking into account both employer and employee contributions towards the cost of coverage for the benefit package under which the employee is receiving coverage. The 30% maximum being extended to 50% in the instance the incentive is being offered for successfully achieving the outcome of being tobacco free. If, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) participate in the health-contingent wellness program, the reward cannot exceed the applicable percentage of the total cost of the coverage in which the employee and any dependents are enrolled (such as family coverage or employee-plus-one coverage).

As more wellness companies and programs emerge, more studies are being conducted to show the importance of incentives in changing human behavior. This increase in incentives was designed specifically to promote higher engagement and statistically higher results. Despite wellness only having a short history in America, studies have been able to show health-contingent wellness programs provide a higher return on investment and are significantly more successful when incentive based.[17] It is assumed the Departments considered these statistics,

[14] 45 C.F.R. 146.121.

[15] 78 FR. 33159 para (D)(4) (2013). "For this purpose, it must have a reasonable chance of improving the health of, or preventing disease in, participating individuals, and not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease. The proposed regulations also stated that, to the extent a plan's initial standard for obtaining a reward (or a portion of a reward) is based on results of a measurement, test, or screening that is related to a health factor (such as a biometric examination or a health risk assessment), the plan is not reasonably designed unless it makes available to all individuals who do not meet the standard based on the measurement, test, or screening, a different, reasonable means of qualifying for the reward. *Id*.

[16] *Compare* 78 FR. 33159 para (D)(1) (2013) *with* 66 FR. 1379, January 8, 2001.

[17] *See* Kevin G. Volpp, "Reward-Based Incentives for Smoking Cessation: How a Carrot Became a Stick," *The Journal of the American Medical Association*, March 5, 2014. *See also* Michael P. O'Donnell, "Four Lenses through Which to Develop Wellness Incentive Policies." *American Journal of Health Promotion*, March 2014, Vol. 28, No.4 pp. iv-vii; Nico Pronk, "Best Practice Design Principles of Worksite Health and Wellness Programs," *ACSM's Health &Fitness Journa*l, January/February 2014, Vol. 18, No. 1, p. 42-46.

as despite only a small percentage of current wellness programs coming close to the previous maximum of 20%, the Departments are looking for people to expand their incentives to promote engagement and better results.[18]

Moreover, evidence suggests engagement is highly correlated with the maximum possible reward, not the amount actually received.[19] The highest possible reward is the key driver in engagement in wellness, rather than the expected value of the received reward. The ACA's choice to expand the value of the highest possible reward allows companies flexibility in the rewards offered, in turn promoting more interest and results in wellness programs. The larger possible reward under the ACA regulations allows programs to offer such things as a mall or points redemption system with points earned for participating in healthy activities. Members can set their sights on the top prizes for redemption, such as a bike, tablet or TV, despite in actuality only achieving such results to be able to redeem a few books or movies. One may compare this thinking to participating in a lottery; a higher possible prize increases the number of participants and the frequency of participation among them.

Health Contingent Program Requirement Three: Reasonable Alternative Standard

The ACA states that a reasonable alternative must be provided to all individuals engaging in a Health Contingent Program who do not meet the initial standard related to a health factor. The initial standard may be performing or completing an activity relating to a health factor, or it may be attaining or maintaining a specific health outcome. For example, having three out of five biometric results in a health range as defined by the company or providing verification you are a non-smoker. The group of individuals that must be offered a reasonable alternative standard differs when comparing the requirements for an activity-only wellness program to the requirements for an outcome-based wellness program. However, the requirements that the alternative be reasonable, taking into account an individual's medical condition, and the option of waiving the initial standard, remain the same.

All facts and circumstances are taken into account in determining whether a plan or issuer has provided a reasonable alternative standard, including but not limited to, the following factors listed in these final regulations:

1) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program and may not require an individual to pay for the cost of the program.

2) The time commitment required must be reasonable.

3) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

4) If an individual's personal physician states that a plan standard is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness.[20]

Plans and issuers may provide reasonable alternative standards that are themselves health-contingent wellness programs. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, the reasonable alternative standard must comply with the requirements for activity-only programs as if it were an initial program standard. For example, if a plan or issuer provides a walking program as an alternative to a running program, the plan must provide reasonable alternatives to individuals who cannot complete the walking program because of a medical condition. Although plans may choose to utilize participatory programs, such as

[18] Soeren Mattke, Christina Huang et al. "Workplace Wellness Programs Study, Final Report," *Rand Health* sponsored by the U.S Departments of Labor and Health and Human Services, pg. 85-86 (last accessed March 17, 2014 at http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf).

[19] *Insights from Vitality*, Engagement Study 2014: A Technical Brief. "A strong positive correlation exists between maximum incentive value on offer and the health participation rate. As expected, the design shows decreasing marginal returns for additional amounts. On average, there is a 1% increase in participation for every $20 of added potential incentive." *Id.*

[20] 78 FR. 33163-33166 (2013).

educational programs, when designing reasonable alternative standards, the requirement to provide a reasonable alternative standard to all individuals who do not meet or achieve a particular health outcome is not intended to transform all outcome-based wellness programs to participatory wellness programs.

Moreover, the final regulations provide that the reasonable alternative standard, taking into account the individual's circumstances, cannot be a requirement to meet a different level of the same standard without additional time to comply. For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. However, if the initial standard is to achieve a BMI less than 30, a reasonable alternative standard for the individual could be to reduce the individual's BMI by a small amount or a small percentage over a realistic period of time, such as within a year. In addition, the final rules clarify that in order for an alternative standard to be reasonable, the time commitment must be reasonable. For example, requiring nightly attendance at a one-hour class would be unreasonable.

The requirement for a reasonable alternative to be offered is nothing new to wellness. The Departments, in writing the ACA rules, merely utilized this legislation as a forum to clarify the expectations all members should have when engaging in a corporate wellness program, as well as expanding the notion of the reasonable alternative to allow for a more personalized approach. Requiring programs to recognize and accommodate the recommendation of the individual's personal doctor is a far better approach to promoting health and wellness than requiring individuals to meet non-personalized and static goals.

Health Contingent Program Requirement Four: Notification of the Reasonable Alternative Standard

These final regulations, in addition to requiring a reasonable alternative standard, also require plans and issuers to conspicuously disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program. The ACA clarifies that for any health-contingent wellness program, a disclosure of the availability of a reasonable alternative standard must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. For outcome based-wellness programs, this notice must also be included in any notification that an individual did not satisfy an initial outcome-based standard. However, if plan materials merely mention that such a program is available, without describing its terms or requirements, this disclosure is not required. For example, a summary of benefits and coverage which notes that cost sharing may vary based on participation in a diabetes wellness program, without describing the standards of the program, would not trigger this disclosure. In contrast, a plan disclosure that references a premium differential based on tobacco use, or based on the results of a biometric exam, is a disclosure describing the terms of a health-contingent wellness program and, therefore, must include disclosure of a reasonable alternative standard.

The reasonable alternative notification requirement has created transparency in wellness. This transparency can only aid in creating wellness programs and initiatives which speak to a wider audience and promote engagement in a more varied population. Those who previously read requirements which they knew they could not possible satisfy are now immediately presented with an option which still encourages improvement in health and wellness, but does not automatically make the member feel as though they are unqualified to participate.

Health Contingent Program Requirement Five: Reasonable Design

Finally, the ACA has maintained HIPAA's original stance that all wellness programs must be reasonably designed. The regulations state that a wellness program is reasonably designed if it has 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.[21] The regulations fail to go further into detail about what each of these requirements means, any standards

[21] 78 FR. 33162 (2013).

which must be met to satisfy them, and particularly, unlike many of the other requirements, what constitutes reasonable design is not provided sufficient commentary including examples to allow issuers to deduce the implications of this standard.

The preamble to the 2006 Nondiscrimination rules stated that the "reasonably designed" standard was designed to prevent abuse, but otherwise was "intended to be an easy standard to satisfy . . . There does not need to be a scientific record that the method promotes wellness to satisfy this standard. The standard is intended to allow experimentation in diverse ways of promoting wellness."[22] The preamble also stated that the drafters did not "want plans and issuers to be constrained by a narrow range of programs . . . but want plans and issuers to feel free to consider innovative programs for motivating individuals to make efforts to improve their health."[23]

The Affordable Care Act: Are the Critics Right?

After publication of the ACA, the commentary which followed was colorful and passionate, but somewhat mistaken. Many felt that highlighting a required reasonable alternative standard among other aspects of the ACA were major steps on a path to "ruin wellness."[24] The claims implied the ACA was too soft on those participants who needed to improve, essentially providing an excuse from or "easy way out" of meeting minimum standards to get the same incentive that their hard working or healthy counterparts were to receive. Those who work in the wellness field saw complaints and stress from customers new to wellness and worried the incentive structure they wanted would not work under the new structure.[25]

The claims of the critics are quite short sighted as their claims of weakening wellness are neither the goal nor the result of the ACA. Rather the criticisms should focus on the next steps which should be taken regarding these regulations. The Departments aimed to create wellness programs that encourage all, regardless of health or wellness level, to be able to engage and improve. When evaluating the regulations, it is clear that the ACA was a monumental step in achieving this goal by better regulating and defining the requirements established previously established by the Departments. As mentioned, studies indicate that the expansion of the incentive maximum will exponentially improve engagement.[26] Moreover, contrary to the critics' claims, the ACA did not falter in its enhancement of the reasonable alternative, but rather the only error can be found in the Departments' reluctance to more specifically define the threshold of what qualifies as a "reasonably designed" wellness program.

Reasonable Alternative Standards

The most contentious aspect of the ACA, and at the center of most debates, is the heightened awareness and requirements surrounding reasonable alternative standards. Critics argue that the expanded definition of a reasonable alternative standard will negate the purpose of corporate wellness. There is fear members will seek easy alternatives rather than improving their health merely to achieve an incentive. The key, however, is not the need for the reasonable alternative that will dictate a shift in wellness, but rather the plan or issuers choice in determining their reasonable alternatives.

For example, a lot of discussion has surrounded the goal of employers to create a smoke free employee base. The ACA mandates that if an incentive is to be provided for those who certify to being a nonsmoker, the employer must also offer a reasonable alternative for those who smoke. A reasonable alternative could include enrolling in or completing a smoking cessation course. The critics feel this is

[22] 78 FR. 33162 (2013).

[23] *See* 71 FR at 75019.

[24] *See* Matt Dunning, "Nondiscrimination Rules for Wellness Programs Create Hurdles for Employers," *Business Insurance*, June 16, 2013.

[25] In an interview with Francois Millard and Tal Gilbert, representatives of The Vitality Group, a leader in wellness, mention of a fear of an ineffective program was abundant shortly after the publication of the ACA. "Groups, particularly those aimed at quitting smoking, were fearful the requirement of a reasonable alternative to be made so apparent to its population would undermine employees' incentive to quit smoking. This fear was seen throughout our business, particularly with customers newly implementing a wellness program."

[26] *Insights from Vitality*, Engagement Study 2014: A Technical Brief. "A strong positive correlation exists between maximum incentive value on offer and the health participation rate. As expected, the design shows decreasing marginal returns for additional amounts. On average, there is a 1% increase in participation for every $20 of added potential incentive." *Id.*

not fair, it is not promoting an employee to quit- it allows a member to go through the motions and still achieve an incentive as if they were a non-smoker. However, the goals of the ACA were not to create a simpler alternative, or easy resolution for those who did not want to improve. Rather the Departments aimed to require plans or issuers to think more clearly and create better strategies to benefit the plan and the member when designing their wellness program. This means, in the instance of quitting smoking, the intent was for the plan to look at the big picture and strategize accordingly. In year one,, a plan may require a member to be a non-smoker or to enroll in a non-smoking class. This gets employees involved, aware of the program and motivated to, at minimum, sign up. In year two, however, the plan design would elevate expectations, providing an incentive to those employees who are non-smokers or who successfully complete an entire smoking cessation course, rather than just enroll. Each year thereafter the plan can continue to make the reasonable alternative standard more and more stringent.

The critics also failed to consider the credibility that a well suited and strategically designed reasonable alternative standard will enhance any current wellness program. Wellness is still an evolving field, one toward which employees nationwide face hesitation and distrust. Wellness can at times be perceived as employer interference, not a tool for behavioral improvement. Adding a transparent level of fairness creates a comfort in each employee. It adds assurance that the employer or plan is instituting this program for the benefit of the employees. The reasonable alternative, if used correctly, can be a tool to not only engage those that may be unmotivated in light of unascertainable goals, but also those who are untrusting or hesitant of the newer notion of corporate wellness.

The Departments note that plan sponsors will have strong motivation to identify and provide reasonable alternative standards that have positive net economic effects, in addition to positive health effects. Plan sponsors will be disinclined from providing alternatives that undermine their overall wellness program and worsen behavioral and health outcomes, or that make financial rewards available to participants absent meaningful efforts to improve their health habits and overall health. Instead, plan sponsors will be inclined to provide alternatives that sustain or reinforce plan participants' incentive to improve their health habits and overall health, and/or that help participants make such improvements. No plan should be motivated to provide any incentive that would be viewed as a handout to employees regardless of the effort they put in.

The requirement to provide a reasonable alternative standard is intended by the Departments to eliminate instances where wellness programs serve only to shift costs to higher risk individuals and instead to increase instances where programs succeed at helping high risk individuals improve their health as they do now. Holding employers, plans or issuers to more stringent guidelines requires them to be more proactive and strategically consider the alternatives they are offering. The ACA achieves this motive, not only by more clearly dictating the requirements of a conspicuous reasonable alternative but requiring a transparency to its entire member base of the options involved.

Reasonable Design

Not much attention has been paid to the final requirement of all health-contingent wellness programs: reasonable design. This requirement has been unchanged and untouched since wellness regulation was first written. However, despite critics' focus on the stringent requirements of reasonable alternatives, the real weakness of the ACA is in the failure to change or adapt the requirement of reasonable design. As the wellness space evolves and grows in the United States, it is important for the administrative agencies to continue to add regulations around reasonable design. The goal of the original regulations was to allow for wellness to grow and evolve naturally; allowing for trial and error, so long as it was done in a reasonable manner.

A mandate for statistical evidence of a program's ability will only move towards an improvement in the space. The critics should not be focusing on the need for more stringent standards for the programs which may be allowed in the marketplace.[27] The ACA's requirement of reasonable design as it is

[27] *See* David Orentlicher, "Health Care Reform and Efforts to Encourage Healthy Choices by Individuals," Indiana University Robert H. McKinney School of Law Research Paper No. 2014-6.

currently defined, "has a reasonable chance of improving the health of, or preventing disease in, participating individuals" should require more than a mere "reasonable chance". There needs to be a call for verifiable proof that either the program itself works or the methods the program is looking to implement have documented evidence supporting the notion that such methods should in the future work. Holding on to the idea that all programs which offer incentives for acting in a healthy way have reason to work or are reasonably designed is a false reality.

As stated previously, one of the most significant concerns employees claim to have with wellness is a hesitation and fear of ill-willed employer intervention. Comparatively, the amount of regulation that wellness programs are subject to is much lower than the amount of regulation governing traditional health practices such as delivery of health care, including pharmaceuticals and medical procedures. Throughout the health field, evidence of success rates and safety are required before most programs, drugs or device guided procedures are allowed to enter the market. Outside the extremes of drugs and surgery, other health tools require, at a minimum, certain labelling when such a product can provide assurances or receive certification that it is actually healthy. There is no excuse for the wellness space to not be held to similar standards and require at least a minimum level of documented proof a method will be effective.

Conclusion

On January 1, 2014 the ACA became effective, implementing wellness regulations jointly written by The Departments of Health and Human Services, Labor and the Treasury regarding wellness programs in order to encourage appropriately designed, consumer-protective wellness programs in group health coverage. Social media, among other outlets, presented a plethora of critics on the regulations making claims that the ACA regulations were ruining wellness. Their claims were centered on the more stringent rules surrounding reasonable alternative standards. These arguments were ill-informed. The ACA did not in any way harm wellness, but rather took a great step to making wellness a respected and trusted field. The regulations increased the maximum incentive and better defined the needs for reasonable alternative standards. These changes will only work to improve engagement and transparency within these programs. If the critics are going to continue to attack the ACA and seek alteration to the regulations, their efforts need to shift towards the requirement that all programs are reasonably designed. This last piece of the puzzle is the final step in removing wellness from the unknown and confidently placing it into the forefront of every corporate environment.