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# THE MEANS AND ENDS OF WELLNESS PROGRAMS

BY: LAURA D. HERMER, J.D. LL.M.\*

How far should we go in assigning individuals causal responsibility for their own health status and what should the implications of any such assignment be? After all, it seems intuitive that each of us is best positioned to maintain our own health, best understands the consequences of not doing so, and should therefore be held accountable for it. Yet, as Professor Daniel Wikler observed many years ago, the merits of these assumptions are far from clear.<sup>1</sup> It may be, he warned, “that the lack of a debate over the merits of assigning responsibility for health to the individual will lead to the uncritical and unhesitating adoption of the associated political and moral program.”<sup>2</sup>

Thirty years later, we are seeing the fruit of this gradual and piecemeal adoption ripple through the sphere of health policy and into people’s everyday lives. Grocery shoppers and chain restaurant customers can choose to purchase reduced-calorie, gluten-free, or other “healthy” products. Consumers can buy devices or apps allowing them to track heart rate, personal sleep cycles, steps taken, etc.<sup>3</sup> Smokers can choose a variety of implements intended to help them quit, from nicotine patches to vaping devices.<sup>4</sup> Employers offer managed care plans and virtual primary care services, increase deductibles and cost-sharing amounts to shift health care expenses to employees, and institute programs intended to encourage improved employee wellness, among other changes.<sup>5</sup>

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1. See Daniel Wikler, *Who Should Be Blamed for Being Sick?*, 14 HEALTH EDUC. Q. 11 (1987), reprinted in PUBLIC HEALTH ETHICS: THEORY, POLICY, PRACTICE 89 (Ronald Bayer, Lawrence O. Gostin, Bruce Jennings et al., eds. 2007).

2. *Id.* at 95.

3. See, e.g., Christian de Looper, *The 10 Best Healthcare Apps*, DIGITAL TRENDS (2019), <https://www.digitaltrends.com/mobile/best-health-apps/> (detailing features of particular fitness, diet, and other health apps available).

4. *Want to Quit Smoking? FDA-Approved Products Can Help*, FDA (Dec. 12, 2017), <https://www.fda.gov/consumers/consumer-updates/want-quit-smoking-fda-approved-products-can-help> (outlining available products to assist with such as nicotine replacement therapies and prescription smoking cessation medicines).

5. See *infra*, Part II.A.

Additionally, most states have embraced managed care plans in Medicaid for all but the frailest populations.<sup>6</sup> Other states have sought with varying degrees of success to institute personal responsibility provisions to reward or punish health-related or other behaviors exhibited by Medicaid beneficiaries.<sup>7</sup>

Few would deny that most adults have a major role in achieving and maintaining their own health. However, it is not at all clear where one should draw the line between what is freely chosen and what is determined by forces outside a person's control. For example, in some cases the financial ability to obtain or retain health insurance has become tied not just to financial factors, but to personal improvement efforts.<sup>8</sup> An uncritical and outsized notion of the responsibility individuals have for their health underlies this trend. While health coverage can make it financially possible for people to access health care, coverage is not about improving health per se. Medical care plays only a small role in most people's overall health, and often<sup>9</sup> social, environmental, and personal factors are far more important.<sup>10</sup> Incentivizing an individual to take better care of her health by adding incentives or penalties to her health coverage, even if done as reasonably as possible, may be far less effective than altering key social and environmental factors that are strongly linked to health status.<sup>11</sup>

Altering health coverage to include wellness incentives in an effort to manipulate individual behavior is a problematic trend. On the one hand, including such incentives ostensibly furthers the principle of distributive justice by encouraging individuals to take more responsibility for their health. But, on the other hand, such incentives not only misconstrue the purpose of coverage, but also arguably create an injustice by inappropriately elevating individual

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6. See, e.g., *State Health Facts, Medicaid Managed Care Penetration Rates by Eligibility Group*, KAISER FAMILY FOUND. (2019), <https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (showing that, in at least some states with substantial Medicaid managed care penetration, a smaller percentage of aged and disabled beneficiaries are enrolled in managed care than other Medicaid populations).

7. See *infra* Part II.B.

8. See *infra* note 125 and accompanying text.

9. See, e.g., J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, *The Case For More Active Policy Attention To Health Promotion*, 21 HEALTH AFFAIRS 78, 83 (2002) (stating that, “[o]ver the course of the twentieth century, about five of the thirty years of increased life expectancy could be attributable to better medical care”).

10. See, e.g., Tiffany Fitzpatrick, Laura C. Rosella, Andrew Calzavara et al., *Looking Beyond Education and Income: Socioeconomic Status Gradients Among Future High Cost Users of Health Care*, 49 AM. J. PREVENTIVE MEDICINE 161, 163 (2015) (“In the unadjusted models . . . , [high cost users] were most strongly associated with low income and low household education. Strong gradients of association were noted for lower household income, higher area dependency, and lower ethnic concentration. After adjusting for age, these associations were attenuated, with the exception of home ownership and food security, which were strengthened. . .”).

11. See *infra* Part III.

responsibility for health while ignoring the larger, systemic contributors to chronic diseases and conditions. Consequently, this injustice is harmful to all of us. Making access to health coverage contingent on health improvement efforts decreases access to health care services by making it more difficult or costly for individuals to obtain, retain, and use coverage, and inappropriately and disproportionately burdens the more vulnerable, without outweighing benefits.<sup>12</sup> This practice focuses attention away from the larger causes of the problems, while blaming individuals for matters that are not completely within their control.

This article will examine these issues as they manifest in private and public coverage in the form of employer-sponsored wellness programs and Medicaid personal responsibility requirements.<sup>13</sup> Part I will examine the history and increasing devolution of responsibility for health onto individuals through changes in employer-sponsored wellness programs and personal responsibility requirements in Medicaid programs.<sup>14</sup> Part II will examine ethical considerations regarding these changes.<sup>15</sup> The article will conclude by showing that the degree to which we currently allocate responsibility for health onto individual behavior versus the government is ethically problematic and likely to lead to poor societal and financial outcomes. Individual choice has a role to play, but only in concert with collective legal action on larger policy issues.<sup>16</sup>

#### PART I: CONTEXTUALIZING WORKPLACE WELLNESS PLANS AND MEDICAID PERSONAL RESPONSIBILITY REQUIREMENTS

The focus on personal responsibility for health in the context of health coverage predates the George W. Bush administration, but it sharpened during that presidency. When Bush first took office, he faced complementary problems with respect to health coverage. On the one hand, a growing percentage of Americans lacked health insurance,<sup>17</sup> while at the same time health care costs and health coverage costs were rising.<sup>18</sup> Neither President Bush nor the 107<sup>th</sup> and 108<sup>th</sup> Congresses were inclined to address either issue through large, government

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12. *See infra*, notes 76–81, 108–111 and accompanying text.

13. *See infra* Part II.B.

14. *See infra* Part I.

15. *See infra* Part II.

16. *See infra* Part III.

17. ROBERT J. MILLS, U.S. DEP'T OF COMMERCE, P60-215, HEALTH INSURANCE COVERAGE: 2000 (2001), <http://www2.census.gov/library/publications/2001/demographics/p60-215.pdf>.

18. *See* Sherry Glied, *Health Care Costs: On the Rise Again*, 17 THE J. OF ECON. PERSP. 125 (2003).

solutions. Instead the administration focused on limited solutions that made use of the private market.<sup>19</sup>

A number of strategies were employed to address the issue of rising health care costs, but one in particular became important for our purposes here: wellness programs. These are “program[s] of health promotion or disease prevention” that meet specific statutory requirements in an effort to make individuals healthier and, in the process, help keep down health care costs.<sup>20</sup> Wellness programs generally must be devised to help individuals become or stay healthy.<sup>21</sup> They may involve measures such as subsidized gym memberships, biometric screenings, health risk assessments, or structured programs to help people lose weight, exercise more, or stop smoking.<sup>22</sup> The benefit of participation need not take the form of a reward, but may instead be the “absence of a surcharge.”<sup>23</sup> This strategy permits the entity providing coverage to charge more money to individuals who refuse to participate in particular kinds of wellness programs or who fail to meet the program requirements.<sup>24</sup>

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19. See Medicare Modernization Act of 2003, Pub L. No. 108-173, 177 Stat. 2066 (2003) (codified as amended in scattered sections of 21 U.S.C.) (providing the only significant reform to Medicare during that time).

20. 42 U.S.C. § 300gg-4(j)(1)(A) (2012). See also CTR. FOR MEDICARE AND MEDICAID SERVS., *Medicaid Incentives for the Prevention of Chronic Diseases Model*, <https://innovation.cms.gov/innovation-models/mipcd> (providing grants to states under the Affordable Care Act to institute “comprehensive, evidence-based, widely available, and easily accessible” prevention programs to provide incentives to Medicaid beneficiaries who “demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors”); *Trump Administration Announces Opportunity for States to Participate in Wellness Program Demonstration Project*, CTR. FOR MEDICARE AND MEDICAID SERVS. (Sept. 30, 2019), <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-opportunity-states-participate-wellness-program-demonstration-project> (describing an opportunity for up to 10 states to implement a wellness program for individuals purchasing coverage on the individual market).

21. 42 U.S.C. §§300gg-4(j)(1)(A) (2012) (describing wellness programs as being offered by employers to promote health); § 300gg-4(j)(3)(B) (stating that wellness programs that require individuals to satisfy a requirement based on a health status factor “shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.”).

22. 26 C.F.R. § 54.9802-1(f)(1)(ii), (iv), (v) (2019) (providing examples of participatory wellness programs, activity-only wellness programs, and outcome-based wellness programs).

23. 42 U.S.C. § 300gg-4(j)(3)(A) (2012). “A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.” *Id.*

24. 26 C.F.R. § 54.9802-1(f)(3)(iv) (2019). Individuals who cannot meet the requirements of a wellness program due to a medical condition must be provided a “reasonable alternate standard” to meet in order to obtain a reward. *Id.*

*A. Employer-Sponsored Wellness Programs*

Employer-sponsored wellness programs have been in existence for quite some time, pre-dating the Americans with Disabilities Act (hereinafter “ADA”) of 1990. They started appearing in the 1970s as corporations sought ways to hold down employee health care costs, reduce absenteeism, improve morale, and increase productivity.<sup>25</sup> These programs take two different forms. The first, “participatory” wellness programs, offer employees access to some program like a free or discounted gym membership, regardless of outcome.<sup>26</sup> Such programs seek to prioritize “healthy” behaviors, but do so by offering carrots, not sticks. These programs are offered on a take-it-or-leave-it basis with no negative outcome for failing to participate. As such, they do not impinge on a person’s freedom or privacy, but instead increase an individual’s options. The second, “health-contingent” wellness programs, require participants to meet one or more health-related goals.<sup>27</sup> If a participant meets their goal, then they either receive a reward or avoid incurring a penalty.<sup>28</sup> Unlike participatory wellness programs, health-contingent wellness programs raise a number of problems, and are the subject of further discussion, below.

The rising cost of health care in the 2000s, along with the carve out in the Health Insurance Portability and Accountability Act of 1996 (hereinafter “HIPAA”) for wellness programs, gave wellness programs a boost in the initial years of this century.<sup>29</sup> In the 2000s, employers increasingly incentivized participation in these voluntary programs by providing, as permitted under HIPAA, either an incentive merely for participating in a non-health contingent wellness program, or up to a 20% discount on employee insurance premium costs to employees who meet a particular health goal in a health contingent wellness program.<sup>30</sup> Between 2006 and 2009, for example, the percentage of employers

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25. Peter Conrad, *Wellness in the Workplace: Potentials and Pitfalls of Work-Site Health Promotion*, 65 MILBANK Q. 255, 257 (1987).

26. U.S. DEP’T OF LABOR, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART V AND MENTAL HEALTH PARITY IMPLEMENTATION, 6 (2010), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-v.pdf>.

27. *Id.*

28. *Id.* For a list of some typical incentives and penalties that may be found in such wellness programs see, e.g., Bahaudin G. Mujtaba & Frank J. Cavico, *Corporate Wellness Programs: Implementation Challenges in the Modern American Workplace*, 1 INT. J. HEALTH POL’Y & MGMT. 193, 196 (2013) (listing strategies such as offering free gym membership, reducing premiums for losing weight or lowering cholesterol, charging overweight employees and smokers a health premium surcharge, and charging a premium surcharge to employees who fail to obtain preventive healthcare).

29. See 42 U.S.C. § 300gg-4(j)(3) (permitting employers to reward employees based on their achievement of particular health status factors in the context of permitted wellness programs).

30. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75014, 75017-18 (Dec. 13, 2006) (to be codified at 45 C.F.R. pt. 146) (describing the incentive as exceptions to HIPAA’s strict nondiscrimination provisions to allow employers to provide rewards to employees for participation in wellness programs, regardless of outcome).

offering health plans who also offered a wellness program rose from 27% to 74%.<sup>31</sup>

Wellness programs became increasingly well-established under the Obama administration and were boosted, at least in theory, from the Affordable Care Act's (hereinafter "ACA") expansion of the maximum possible premium discount that could be offered under HIPAA from 20% to 30% in the case of most health contingent wellness programs, or 50% in the case of smoking cessation wellness programs.<sup>32</sup> By 2016, 83% of employers who offer health insurance also offered at least one wellness program, and 42% of large employers<sup>33</sup> offering wellness programs offered a financial incentive to employees to participate.<sup>34</sup> Fifty-three percent of large employers offered their employees the opportunity to complete a biometric screening measuring physical characteristics such as blood pressure, body-mass index, or cholesterol, and nearly 60% of those employers offered a financial reward to participating

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31. Kaiser Family Found., *Employer Health Benefits, 2006 Annual Survey, Section 12: Employer Options and Health Management Programs*, 1, 138 (2006), <https://www.kff.org/wp-content/uploads/2013/04/7527.pdf>; Kaiser Family Found., *Employer Health Benefits, 2010 Annual Survey, Section 12: Wellness Programs, Health Risk Assessment, and Disease Management Programs*, 1, 170 (2010), <https://www.kff.org/wp-content/uploads/2013/04/8085.pdf>.

32. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33158, 33159, 33167 (June 3, 2013) (to be codified at 25 C.F.R. pt. 54). The expansion of incentive values may have had little practical effect in most employment settings, given how small most wellness plan incentives have been in relation to their potential maximum amount. An Employee Benefit Research Institute study included data showing that in 2014 of the large employers providing a financial incentive to complete a health risk assessment, 64% offered an incentive valued at \$500 or less. Paul Fronstein and M. Christopher Roebuck, *Financial Incentives, Workplace Wellness Program Participation, and Utilization of Health Care Services and Spending*, 417 EBRI ISSUE BRIEF 4, 6, 8 (2015). RAND found in its 2012 Employer Survey that the median incentive value among employers offering an incentive was \$300. Soeren Mattke et al., *Workplace Wellness Programs Study: Final Report*, RAND 1, 76 (2013), [https://www.rand.org/content/dam/rand/pubs/research\\_reports/RR200/RR254/RAND\\_RR254.pdf](https://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf). More recently, the 2019 Kaiser Employer Health Benefits Annual Survey found that 54% of large firms offering any incentive to complete a health promotion or screening program offered one with a value of \$500 or less. Kaiser Family Found., *2019 Employer Health Benefits, Section 12: Health and Wellness Programs*, fig. 12.16 (2019), <https://www.kff.org/report-section/ehbs-2019-section-12-health-and-wellness-programs/>. Only seven percent offered an incentive valued at \$2,001 or more. *Id.* Incentives must be valued at more than \$2,001 to approach the upper limits set by the ACA for an average-priced, employer sponsored, individual health insurance plan. See Kaiser Family Found., *2019 Employer Health Benefits, Section 1: Cost of Health Insurance*, (2019), <https://www.kff.org/report-section/ehbs-2019-section-1-cost-of-health-insurance/> (finding the average cost of an employer-sponsored, individual plan was \$7,188 in 2019); Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33158-01, 33159, 33167-33161 (June 3, 2013) (to be codified at 25 C.F.R. pt. 54) (increasing the maximum premium discount to 30% of the total cost of employee-only coverage).

33. HIPAA defines large employers as those "who employed an average of at least 51 employees on business days during the preceding calendar year and who employ[] at least 2 employees on the first day of the plan year." 42 U.S.C. § 300gg-91(e)(2).

34. Kaiser Family Found., *Employer Health Benefits, 2016 Annual Survey, Section 12: Health Risk Assessment, Biometrics Screening and Wellness Programs*, 1, 212, 225 (2016), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey>.

employees.<sup>35</sup> Fifty-nine percent of large employers offered employees a health risk assessment tool, and 54% of those firms provided one or more incentives to help induce employees to utilize the tool.<sup>36</sup> These percentages have changed little under the Trump administration.<sup>37</sup>

Despite the wide adoption of wellness programs by many employers, the evidence for the programs' effectiveness is mixed at best. Numerous articles in the legal literature that examine the evidence on the effectiveness of wellness programs have found it wanting.<sup>38</sup> Two recent studies bear remark. In contrast to

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35. *Id.* at 213.

36. *Id.* at 212.

37. See Kaiser Family Found., *Employer Health Benefits, 2018 Annual Survey, Section 12: Health and Wellness Programs* (2018), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018> (providing up to date data on health and wellness programs offered by employers). Approximately 82% of health insurance-offering employers also offered at least one wellness program in 2018. *Id.* at 189. Biometric screening was offered by 50% of large firms and of those 60% offered employees incentives to participate in the screening. *Id.* at 193. Sixty-two percent of large employers offered health risk assessments in 2018 and 51% of these employers also offered incentives to employees to participate in the assessments. *Id.*

38. See, e.g., Lindsay F. Wiley, *Access to Health Care as an Incentive for Healthy Behavior? An Analysis of the ACA's Personal Responsibility for Wellness Reforms*, 11 *IND. HEALTH L. REV.* 635, 665 (2014) (finding that in 2014 "[e]valuation of the impact of these programs is limited. Only about half of employers who have wellness programs report that they have evaluated them"); Kristin Madison, *Employer Wellness Incentives, The ACA, and the ADA: Reconciling Policy Objectives*, 51 *WILLAMETTE L. REV.* 407, 415 (2015) (explaining that it is unclear whether wellness incentives work, and "[a]s is the case for wellness programs in general, the answer is unclear"); Emily Koruda, *More Carrot, Less Stick: Workplace Wellness Programs and the Discriminatory Impact of Financial and Health-Based Incentives*, 36 *B.C. J.L. & SOC. JUST.* 131, 144-45 (2016) (noting, among other issues, that "many studies on the effectiveness of these programs run up against inherent flaws. Selection bias, for example, is a concern. In a study examining the overall health of individuals within a wellness program, if only the healthiest employees enrolled in the program, a comparison between participants and nonparticipants will likely be skewed to show more progress than is actually occurring. Other concerns with conducting studies include low response rates and publication biases" (citations omitted)); Elizabeth A. Brown, *Workplace Wellness: Social Injustice*, 20 *N.Y.U. J. LEGIS. & PUB. POL'Y* 191, 213 (2017) (noting among other issues that "[w]riting in 2013, the [federal agencies charged with analyzing the final rule on Incentives for Nondiscriminatory Wellness Programs] noted that 'currently, insufficient broad-based evidence makes it difficult to definitively assess the impact of workplace wellness programs on health outcomes and cost'" (citation omitted)); Adrianna McIntyre et al., *The Dubious Empirical and Legal Foundations of Workplace Wellness Programs*, 27 *HEALTH MATRIX* 59, 65, 73 (2017) (finding that several reasonably well-devised "studies that rigorously evaluate the experience of individual firms with wellness programs" and "several meta-analyses that have helped frame contemporary discussion around employer-based wellness initiatives" demonstrate that the programs have only "questionable efficacy"); Jessica L. Roberts & Leah R. Fowler, *How Assuming Autonomy May Undermine Wellness Programs*, 27 *HEALTH MATRIX* 101, 111 (2017) (describing how "some of these programs have been described as poorly designed, haphazard, not evidence-based, inadequately resourced, not culturally supported, and ineffective"); Al Lewis, *The Outcomes, Economics and Ethics of the Workplace Wellness Industry*, 27 *HEALTH MATRIX* 1, 13, 23-24, 36 (2017) (detailing the failure of wellness programs to reduce hospital admissions for conditions related to health behavior, the economic ineffectiveness of wellness programs, and problems with assertions of clinical effectiveness in the programs); Camila Strassle & Benjamin E. Berkman, *Workplace Wellness Programs: Empirical Doubt, Legal Ambiguity, and Conceptual Confusion*, 61 *WILLIAM & MARY L. REV.* 1663, 1672-73 (2020) ("In short, the early evidence regarding wellness program effectiveness was fragmentary, poorly operationalized, and often observational,



most prior studies, both were randomized control trials.<sup>39</sup> Both also found the wellness programs they studied to have little significant effect on employee behavior and health outcomes.<sup>40</sup>

The first study – the Illinois Workplace Wellness Study – examined a wellness program implemented at the University of Illinois at Urbana-Champaign.<sup>41</sup> The study offered all 12,459 benefits-eligible employees at the university the opportunity to complete a baseline health and wellness survey in exchange for a \$30 Amazon.com gift card.<sup>42</sup> The 4,834 participants who completed the survey were provided with the chance to participate in the second part of the study.<sup>43</sup> Of those 4,834 participants, 3,300 were randomly chosen to participate in the “treatment” group, whereas the remaining 1,534 were assigned to the control group and were not permitted to participate.<sup>44</sup> All participants completed health surveys and underwent annual biometric screenings.<sup>45</sup> Members of the treatment group were offered monetary rewards to participate in the screening, health risk assessment (HRA), and periodic wellness activities ranging from \$50 to \$350 for the first year of the study and smaller rewards during the second year of the study.<sup>46</sup> The researchers found no statistically significant effect of wellness program participation on health care spending, employee productivity, or employee health behaviors.<sup>47</sup> Of the 42 outcome measures studied, only two yielded any statistically significant difference between participants and nonparticipants during the first year of the study period: (1) participants were more likely than nonparticipants to have had a health screening, and (2) participants were more likely than nonparticipants to believe that the management cared about their health and safety.<sup>48</sup>

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suggesting a surprisingly weak state of the science on program benefit,” and “[n]ewer studies further undermine the assumptions that policymakers drew from the earlier data”).

39. Damon Jones et al., *What Do Workplace Wellness Programs Do? Evidence from the Illinois Workplace Wellness Study*, Q. J. ECON. 1747, 1748-49 (2019); Zirui Song & Katherine Baicker, *Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes*, 321 J. AM. MEDICAL ASS'N 1491, 1492 (2019).

40. See *infra* notes 44-45, 53-56 and accompanying text.

41. Jones, et al., *supra* note 39, at 1747 n.\*.

42. *Id.* at 1754-56.

43. *Id.*

44. *Id.* at 1756 (indicating that members of the control group were “notified they may be contacted for follow-up surveys in the future,” and therefore any contact with this group was greatly reduced).

45. *Id.* (noting that the first step of the program “included a biometric health screening and an online [health risk assessment]”).

46. *Id.* at 1757, 1785-86 (noting that rewards were decreased during the second year due to a smaller budget and “the diminished effect of incentives on participation” during the first year).

47. *Id.* at 1776-79.

48. *Id.* at 1779.

The second study, conducted by Zirui Song and Katherine Baicker, was a follow-up to their widely cited 2010 wellness program study.<sup>49</sup> It examined a wellness program implemented at 20 randomly-selected BJ's Wholesale Club worksites.<sup>50</sup> An additional 20 randomly-selected BJ's Wholesale Club worksites were selected as primary controls, and 120 remaining sites were secondary controls.<sup>51</sup> The wellness program consisted of eight modules lasting four to eight weeks, covering health and wellness topics.<sup>52</sup> Participants typically received a \$25 BJ's gift card for completion of a module, with overall potential incentives totaling \$250 on average.<sup>53</sup> At the treatment sites, 35.2% of employees completed at least one wellness program module, and 21.4% completed at least three.<sup>54</sup> At the 18<sup>th</sup> month of the program, 25.8% of employees participated in the health assessment survey and 25.5% participated in the biometric screening.<sup>55</sup> Workers at treatment sites were 8.3% more likely than those at control sites to report engaging in physical exercise and 13.6% more likely to report engaging in active weight management, but otherwise reported few statistically significant differences in health behaviors.<sup>56</sup> There were no statistically significant differences in clinical measures of health, health spending, or health care utilization between treatment and control groups.<sup>57</sup> There was also no significant effect on absenteeism, work performance, or tenure.<sup>58</sup> In short, both the BJ Wholesale Club study and the Illinois Workplace Wellness study found little impact for all the effort and expense involved.<sup>59</sup>

Wellness programs nevertheless persist. In some cases, it may be that they offer a “feel good” strategy for raising employee morale, but other considerations may be at work. For example, HIPAA, as enacted in 1996, only obliquely addressed wellness programs.<sup>60</sup> When the legislation that ultimately became HIPAA was introduced, the Senate bill sponsor described it as “build[ing] upon

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49. See generally Katherine Baicker et al., *Workplace Wellness Programs Can Generate Savings*, 29 HEALTH AFFAIRS 1 (2010) (providing an overview of the 2010 study).

50. Song & Baicker, *supra* note 39, at 1492.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.* at 1495.

55. *Id.*

56. *Id.* at 1495-97.

57. *Id.* at 1497-99.

58. *Id.* at 1499.

59. See *id.*; Jones et al., *supra* note 39.

60. Health Insurance Portability and Accountability Act of 1996 [hereinafter HIPAA], Pub. L. No. 104-191 § 2702(b)(2)(B), 110 Stat. 1936, 1961 (1996) (providing that, notwithstanding HIPAA's protections charging different rates to similarly-situated enrollees in the same group health plan, the plan may nevertheless “establish[] premium discounts or rebates or modify[] otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention”).

and strengthen[ing] the private insurance market by making it easier for individuals and families to obtain health insurance coverage and to keep their coverage when they change jobs.”<sup>61</sup> HIPAA’s portability provisions were a primary focus of the legislation, and in instituting group market protections for individuals with pre-existing conditions, the Act also substantially equalized costs and liabilities for employees, no matter what their health status might be.<sup>62</sup> The law did, however, permit employers to “establish[] premium discounts or rebates or modify[] otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.”<sup>63</sup> In 2006, regulations were ultimately promulgated to institute guardrails for workplace wellness programs in light of HIPAA’s nondiscrimination provisions.<sup>64</sup> The regulations were intended in part to prohibit wellness programs from becoming a subterfuge for discrimination.<sup>65</sup>

Nevertheless, permitting health-contingent wellness programs to exist, with their differential treatment of compliant and non-compliant employees, arguably allowed a certain degree of disparate treatment of employees based on health status.<sup>66</sup> Health-contingent wellness programs can be intrusive and punitive, and

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61. *Health Insurance Act of 1995: Hearing on S. 1028 Before the S. Comm. On Labor and Human Resources*, 104th Cong. 1 (1995) (statement of Sen. Nancy Landon Kassebaum, Chairman S. Comm. Of Labor and Human Resources).

62. HIPAA § 2702(b)(1) (codified at 42 U.S.C. § 300gg-4(b)(1)).

63. See HIPAA § 702(b)(2)(B) (codified at 29 U.S.C. § 1182(b)(2)(B)); see also *Interim Rules for Health Insurance Portability for Group Health Plans*, 62 Fed. Reg. 16894, 16939, 16953, 16969 (Apr. 8, 1997) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 144, 146).

64. See *Nondiscrimination and Wellness Programs in Health Coverage in the Group Market*, 71 Fed. Reg. 75,014, 75,017 (Dec. 13, 2006) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 146) (providing discussion on final rules promulgated to prohibit discrimination based on health factors). “The HIPAA nondiscrimination provisions do not prevent a plan or issuer from establishing discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. The 1997 interim rules refer to these programs as ‘bona fide wellness programs.’ In the preamble to the 1997 interim rules, the Departments invited comments on whether additional guidance was needed concerning, among other things, the permissible standards for determining bona fide wellness programs. The Departments also stated their intent to issue further regulations on the nondiscrimination requirements and that in no event would the Departments take any enforcement action against a plan or issuer that had sought to comply in good faith with section 9802 of the Code, section 702 of ERISA, and section 2702 of the PHS Act before the publication of additional guidance.” *Id.* at 75,017.

65. *Nondiscrimination and Wellness Programs in Health Coverage in the Group Market*, 45 C.F.R. § 146.121(f)(3)(iii), § 146.121(f)(4)(iii).

66. “The ‘reasonably designed’ requirement is intended to be an easy standard to satisfy. To make this clear, the final regulations have added language providing that if a program has a reasonable chance of improving the health of participants and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease, it satisfies this standard. There does not need to be a scientific record that the method promotes wellness to satisfy this standard.” *Nondiscrimination and Wellness Programs in Health Coverage in the Group Market*, 71 Fed. Reg. at 75,018 (to be codified at 45 C.F.R. pt. 146) (demonstrating the ease in meeting the standard to be considered nondiscriminatory without scientific data to support the determination, which could leave room; see also Horwitz et al., *infra* note 72 at 474

the rules governing them can be contradictory or unclear. Employers have, for example, required participation in such wellness programs as a necessary condition for participating in the employer's health plan,<sup>67</sup> receiving employer contributions to premiums,<sup>68</sup> and avoiding an insurance surcharge,<sup>69</sup> among other matters. Some of those practices would likely no longer pass legal muster as a result of subsequent rulemaking.<sup>70</sup> However, the contours of permitted requirements remain unsettled.<sup>71</sup>

At the same time, the low participation rate for employees in health contingent wellness programs suggests that these wellness plans both can be and are being used as a means for employers to shift costs onto less healthy employees. In a review of studies of health contingent workplace wellness programs focusing on smoking, obesity, high cholesterol, and hypertension,

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(discussing the potential for wellness programs to be inefficient and even discriminatory if employers shifted costs onto certain employees).

67. See *Equal Emp't Opportunity Comm'n v. Flambeau*, 846 F.3d 941, 945 (7th Cir. 2017) (explaining a situation in which an employee's health insurance was terminated after the employee failed to complete a health risk assessment).

68. See *Equal Emp't Opportunity Comm'n v. Orion Energy Systems*, 208 F.Supp.3d 989, 992 (E.D. Wisc. 2016) (discussing an employer that required employees to either complete a health risk assessment or pay the entire monthly premium).

69. See *Seff v. Broward Cty.*, 778 F.Supp.2d 1370, 1373 (S.D. Fla. 2011) (describing an employer that required employees to pay a \$20 surcharge for not participating in the wellness program).

70. The EEOC disavowed the *Seff* and *Flambeau* court's excessively "expansive[]" use of the ADA's safe harbor provision in 2016 rulemaking: "The employers in *Seff* and *Flambeau* did not use wellness programs in a manner consistent with the application of the safe harbor provision. In neither *Seff* nor *Flambeau* did the employer or its health plan use wellness program data to determine insurability or to calculate insurance rates based on risks associated with certain conditions—the practices the safe harbor provision was intended to permit. Moreover, there is no evidence in either *Seff* or *Flambeau* that the decision to impose a surcharge or to exclude an employee from coverage under a health plan was based on actual risks that non-participating employees posed." Regulations Under the Americans With Disabilities Act 81 Fed. Reg. 31126, 31131 (2016) (to be codified at 29 C.F.R. pt. 1630). Accordingly, the EEOC clarified that a wellness program will only be considered "voluntary" under the ADA if it, inter alia, "(i) Does not require employees to participate; (ii) Does not deny coverage under any of its group health plans or particular benefits packages within a group health plan for non-participation, or limit the extent of benefits... for employees who do not participate; (iii) Does not take any adverse employment action or retaliate against, interfere with, coerce, intimidate, or threaten employees within the meaning... of the ADA. . ." 26 C.F.R. § 1630.14(d)(2)(i)-(iii) (2018).

71. See *AARP v. EEOC*, 267 F. Supp.3d 14, 36-37 (D.C. Cir. 2017) (explaining the problematic nature of the term "voluntary" regarding wellness programs though discussion of its use in the GINA (Genetic Information Nondiscrimination Act) rule). "EEOC's explanation for its chosen interpretation of 'voluntary' in the GINA rule fares no better than its explanation in the ADA rule—principally because EEOC relies primarily on its decision in the ADA rule as the basis for its decision here. Therefore, the Court again finds that the agency has failed to give a reasoned explanation for its decision to interpret the term voluntary to allow incentives of up to 30% of the cost of self-only coverage." *Id.* EEOC subsequently vacated the portions of the ADA and GINA rules concerning maximum incentives permissible for wellness programs. Removal of Final ADA Wellness Rule Vacated by Court 83 Fed. Reg. 65296, 65296 (Dec. 20, 2018) (to be codified at 29 C.F.R. pt. 1630); Removal of the Final GINA Wellness Rule Vacated by Court, 83 Fed. Reg. 65296, 65296 (Dec. 20, 2018) (to be codified at 29 C.F.R. pt. 1635).

Professor Jill Horwitz and colleagues found little evidence that financial incentives encouraged employees to make lasting changes to their behavior.<sup>72</sup> Additionally, the studies offered mixed evidence on whether behavioral changes resulted in cost savings to the employer, therefore calling for more research to be done.<sup>73</sup> The authors hypothesized that any savings may result from cost-shifting onto noncompliant employees rather than from long-term improved employee health.<sup>74</sup> No studies appear to exist that examine this issue, so there is no direct evidence to support or refute this point.<sup>75</sup> However, as Horwitz and her colleagues briefly outline, and as ample other studies evidence, people with lower socioeconomic status are more likely than individuals with higher status to be obese, smoke, or have chronic health problems that might benefit from lifestyle changes.<sup>76</sup> It would stand to reason, they suggest, that wellness programs would, in turn, disproportionately penalize such people.<sup>77</sup>

There are surprisingly few studies examining the relative socioeconomic status of employees who participate successfully, participate unsuccessfully, or opt not to participate in health-contingent wellness programs with financial incentives. One of the few to do so involved a program implemented among public employees in Oregon.<sup>78</sup> The program used the “play or pay” model, where employees who chose not to participate were charged \$35 extra per month for

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72. See Jill Horwitz et al., *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFFAIRS 468, 471-72 (2013).

73. See *id.* at 469, 474.

74. *Id.* at 473-74.

75. *Id.* at 474.

76. *Id.* at 473. See also Fred C. Pampel et al., *Socioeconomic Disparities in Health Behaviors*, 36 ANNUAL REV. SOCIOLOGY 349 (2010) (studying the relationship between socioeconomic status and health behaviors); Michelle Miller et al., *Household Socioeconomic Status Modifies the Association Between Neighborhood SES and Obesity in a Nationally Representative Sample of First Grade Children in the United States*, 20 PREVENTIVE MED. REPORTS 101207 (2020), <https://www.sciencedirect.com/science/article/pii/S2211335520301662> (finding that children living in low-SES homes or low-SES neighborhoods had an increased incidence of obesity); MeLisa R. Creamer et al., *Tobacco Product Use and Cessation Indicators Among Adults — United States, 2018*, 68 MORBIDITY & MORTALITY WEEKLY REP. 1013, 1015 (2018) (finding tobacco use to be higher among people with a GED as compared to those with higher educational attainment and among those earning under \$35,000 as compared to higher incomes).

77. Horowitz et al., *supra* note 72, at 474. “Our review found, at best, conflicting evidence that people with the conditions typically included in wellness programs spend more on health care than others and, therefore, offer particularly attractive sources for cost reduction; respond to financial incentives with behavior changes; and thus improve their health. How can these findings be reconciled with claims that wellness programs have reduced employers’ costs? ... [T]he evidence makes it quite plausible that employees with health risks are paying more for their care, subsidizing the healthy employees in the programs.” *Id.*

78. Bill J. Wright et al., *Does Skin in the Game Matter if You Aren’t Playing? Examining Engagement in Oregon’s Public Employee Health Engagement Model*, 31 AM. J. HEALTH PROMOTION 28, 29 (2017) (stating that socioeconomic status and other demographic and person characteristics were considered variables in the study).

their benefits.<sup>79</sup> The 86% of employees who chose to participate had to complete a health risk assessment and take at least two online health education classes over the next year.<sup>80</sup> Employees were less likely to participate in the program if they earned less than \$40,000 per year, had a lower level of education, and/or had at least one health risk factor, such as obesity or smoking.<sup>81</sup> Nonparticipants cited worries about the intrusiveness of the information they were asked to share (67%), problems with information security (40%), and potential adverse impact on their employment or pay (18%).<sup>82</sup> The study did not examine the monetary effect on the employer or on participants.

The Illinois Workplace Wellness Study, discussed earlier, also examined the socioeconomic status of individuals who participated versus non-participants.<sup>83</sup> Participating employees are less likely to either have high income or to be in the bottom quartile of income as compared to nonparticipating employees.<sup>84</sup> The share of participants who previously participated in a major local “running event is 8.9 percentage points larger than the share among nonparticipants.”<sup>85</sup> Overall, the researchers observed that:

Our results are broadly consistent with these concerns: participating employees are less likely to have very high medical spending, less likely to be in the bottom quartile of income, and more likely to engage in healthy physical activities. At the same time, participating employees are also less likely to have very low medical spending or have very high incomes, which suggests a more nuanced story.<sup>86</sup>

Additionally, the Illinois Workplace Wellness Study had another finding relevant to an issue raised by Horwitz and colleagues.<sup>87</sup> In the 13 months prior to the study, participating employees spent significantly less per month on health care – \$115.30, on average – than those who did not participate, although they were more likely prior to the study’s commencement to have nonzero medical

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79. *Id.*

80. *Id.* at 29-30.

81. *Id.* at 30-31 (observing that employees who make more than \$80,000 per year “were nearly twice as likely to sign up” as employees who make less than \$40,000 per year). The study also found that “more educated employees were more likely to sign up, whereas employees in predominantly ‘blue collar’ agencies (e.g., corrections and law enforcement) were among the least likely to participate.” *Id.* at 32.

82. *Id.* at 31. The authors noted that the “data suggest that employees sometimes feared that the personal health information they were being asked to provide could place their certification, job, or salary at risk.” *Id.* at 32.

83. Jones et al., *supra* note 39, at 1750 (examining evidence of employee “productivity,” which included variables such as sick leave, salary, promotions, hours worked, job satisfaction, and job search).

84. Jones et al., *supra* note 39, at 1771.

85. Jones et al., *supra* note 39, at 1770.

86. Jones et al., *supra* note 39, at 1771.

87. *See* Jones et al., *supra* note 41.

spending than nonparticipants.<sup>88</sup> The researchers observed that, if wellness programs are a significant draw for employees similar to the participants in the study, then employers could realize a substantial reduction in health care costs by offering such a program in recruiting new employees.<sup>89</sup>

### B. Medicaid Personal Responsibility Provisions

Just as in private coverage, personal responsibility provisions also creep into Medicaid.<sup>90</sup> In the context of Medicaid, this trend had its genesis in the Bush administration, which sought to involve private entities to help address public problems.<sup>91</sup> To address the issue of uninsured lower-income Americans, the Bush administration quickly sought to encourage states to partner with private entities, particularly private insurers, in expanding Medicaid coverage through § 1115 waivers.<sup>92</sup> During Bush's first term, states seeking these Health Insurance Flexibility and Accountability (hereinafter "HIFA") waivers did so with the stated goal of expanding coverage to populations who otherwise lacked it, with an emphasis on prioritizing public-private partnerships.<sup>93</sup>

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88. Jones et al., *supra* note 41, at 1767-69.

89. Jones et al., *supra* note 41, at 1772. The researchers further observed, however, that participation in the wellness program had no significant effect on employee retention. Jones et al., *supra* note 33, at 1772.

90. For examples of such provisions, see *infra*, note 99 and accompanying text (discussing, *inter alia*, incentivizing beneficiaries to obtain preventive health services and, if unemployed, to obtain employment).

91. See, e.g., HEALTH CARE FINANCING ADMIN., HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY WAIVER INITIATIVE (2001), <https://web.archive.org/web/20010821103242/http://www.hcfa.gov/medicaid/hifademo.htm> (noting that the Bush administration would prioritize state approaches that used Medicaid and State Children's Health Insurance Program funds to "maximize private health insurance coverage options" for low-income Americans).

92. *Id.* Section 1115 of the Social Security Act allows the Secretary of Health and Human Services, at a state's request, to waive certain federal requirements concerning Medicaid so that the state can test an experimental project that the Secretary believes will further Medicaid's goals. 42 U.S.C. § 1315(a)(1).

93. HEALTH CARE FINANCING ADMIN., *supra* note 91. Between December of 2001 and December of 2006, only fifteen states applied for and received such waivers and many of those states that obtained a waiver had few participants. Adam Atherly et al., *The Effect of HIFA Waiver Expansions on Uninsurance Rates in Adult Populations*, 47 HEALTH SERVS. RES. 939, 940-43 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3423173/pdf/hesr0047-0939.pdf> (including data on enrollment in Table 1). Advocates for the poor were skeptical of the administration's emphasis on private partnerships and some states' attempts to make Medicaid coverage assume features of private coverage. See generally Edwin Park & Leighton Ku, *Administration Medicaid and SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and Increase Cost-Sharing for Low-Income Beneficiaries*, 8-10 (Aug. 15, 2001), <https://www.cbpp.org/archiveSite/8-15-01health.pdf> (noting that populations gaining coverage under HIFA waiver expansions may receive only limited benefits, and that governments may pay more to subsidize skimpy private plans than they would if they simply expanded Medicaid). Moreover, because of budget neutrality requirements and other constraints, the coverage offered to optional or expansion populations through HIFA coverage sometimes limited benefits and/or charged higher costs to beneficiaries. See Robin Rudowitz et al., *A Look at § 1115*

Even in the absence of such partnerships, however, the Bush administration was also open to Medicaid § 1115 waivers that sought merely to make the public program mimic certain features sometimes found in private coverage, such as wellness programs and flexible spending accounts, though often with more punitive effects.<sup>94</sup> We first see states seeking to insert personal responsibility requirements into Medicaid with Florida's "Medicaid Reform" § 1115 Demonstration Waiver, and most notably later in the Healthy Indiana Plan waiver.<sup>95</sup> The latter waiver included features such as a "Personal Wellness and

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*Medicaid Demonstration Waivers under the ACA: A Focus on Childless Adults* (2013), [https://www.kff.org/report-section/section-1115-medicare-demonstration-waivers-issue-brief/#endnote\\_link\\_88161-5](https://www.kff.org/report-section/section-1115-medicare-demonstration-waivers-issue-brief/#endnote_link_88161-5) (pointing out that "many of these [HIFA] waivers provided these adults more limited benefits and charged them higher cost sharing than otherwise allowed in Medicaid. Moreover, some of these waivers covered these adults through a premium assistance model that allowed the state to use Medicaid funds to subsidize the purchase of private insurance that did not meet minimum Medicaid benefit or cost sharing rules without requiring the state to supplement that coverage with wraparound benefits or cost sharing"). See also HEALTH CARE FINANCING ADMIN., *supra* note 91 (explaining the budget neutrality requirements of HIFA). Nevertheless, the program appears to have had at least some positive impact. For example, Adam Atherly and colleagues found that in the six states that implemented a HIFA waiver program with at least 1,000 general participants, "the probability of being insured increased by 6.4 percentage points between the preimplementation and postimplementation periods in the HIFA-eligible sample relative to the control groups." Adam Atherly, Brian E. Dowd, Robert F. Coulam et al., *The Effect of HIFA Waiver Expansions on Uninsurance Rates in Adult Populations*, 47 HEALTH SERVICES RESEARCH 939, 946, 957 (2012). Notably, the study did not consider the nature or quality of the coverage gained in each program, which could be variable given the absence of benefit or other requirements that states had to meet in the coverage they offered to participants who were not otherwise eligible for Medicaid. *Id.* at 943 (highlighting the unique nature of each states' program, making it impossible to identify effect of certain elements of the program. Quality may in many cases have been limited, given CMS's budget neutrality requirement for § 1115 waivers, including HIFA waivers. See, e.g., MACPAC, *Section 1115 Research and Demonstration Waivers*, <https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers/> ("Section 1115 waivers are required to be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver. Although not defined by federal statute or regulations, this requirement has been in practice for many years").

94. See generally Laura D. Hermer, *Personal Responsibility: A Plausible Social Goal, but not for Medicaid Reform*, 38 HASTINGS CENTER REPORT 16, 17 (2008) (discussing measures the George W. Bush administration sought to promote in state Medicaid plans and § 1115 waivers).

95. See CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00206/4, MEDICAID REFORM SECTION 1115 DEMONSTRATION (2006) [hereinafter Florida Section 1115 Demonstration STCs],

[https://ahca.myflorida.com/medicaid/Policy\\_and\\_Quality/Policy/federal\\_authorities/federal\\_waivers/Archive/waiver/pdfs/cms\\_special\\_terms\\_and\\_conditions.pdf](https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/Archive/waiver/pdfs/cms_special_terms_and_conditions.pdf) (providing the Special Terms and Conditions (STCs) for the Florida Medicaid Reform §1115 Medicaid Demonstration which describes details on the nature of the program; CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00206/4, HEALTHY INDIANA PLAN (2008) [hereinafter Indiana Section 1115 Demonstration STCs], <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-HIP/in-healthy-indiana-plan-stc-01012008-12312012-amended-012010.pdf> (providing the Special Terms and Conditions (STCs) for Indiana's Healthy Indiana Plan §1115 Medicaid Demonstration which describes details on the nature of the program). In Florida's waiver approval STCs, "patient responsibility and empowerment" was cited as a key "principle of reform." Florida Section 1115 Demonstration STCs at 1. CMS's Special Terms and Conditions for the waiver noted that, under the waiver, beneficiaries will "be expected to take an active



Responsibility” (POWER) Account, to which certain beneficiaries had to contribute as a condition of maintaining benefits.<sup>96</sup> The Special Terms and Conditions of that waiver, as granted by the Centers for Medicare and Medicaid Services (hereinafter “CMS”), identified the goals Indiana expected to achieve with the waiver – including “Prevention: Encourage individuals to stay healthy and seek preventive care” and “Personal Responsibility: Give individuals control of their health care decisions and incentivize positive health behaviors.”<sup>97</sup> In approving this waiver, CMS apparently decided for the first time that prioritizing healthiness and personal responsibility ostensibly fell within the objectives of Medicaid.<sup>98</sup>

The mainstreaming of emphasizing health and inserting personal responsibility requirements in Medicaid started in earnest with the Florida and Indiana waivers, but the worst excesses of these features were kept at least partially in check through the Bush administration’s apparent respect for § 1115’s requirement to prioritize the goal of medical assistance in granting Medicaid waivers.<sup>99</sup> Not until the Obama administration, ironically, did Medicaid personal responsibility requirements really take off.<sup>100</sup>

CMS under the Obama administration was initially disinclined to grant § 1115 waivers that did not hew closely to Medicaid’s purpose of providing medical assistance to qualified individuals and families. Many HIFA waivers

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role in their health care. *Id.* They will have the flexibility to choose from a variety of benefit packages and be able to choose the package that best meets their needs. Additionally, they will be rewarded for demonstrating healthy practices and personal responsibility.” *Id.* CMS did not, however, specifically identify these – or any other waiver feature, for that matter – as furthering the objectives of Medicaid generally. *See id.* (failing to discuss how these requirements advances the goals of Medicaid).

96. Indiana Section 1115 Demonstration STCs, *supra* note 95, at 1-2. Additionally, if a beneficiary regularly obtained certain preventive services, she could carry over unused balances in her “POWER” account from year to year. *Id.* at 23-24.

97. Indiana Section 1115 Demonstration STCs, *supra* note 95, at 2-3.

98. Indiana Section 1115 Demonstration STCs, *supra* note 95, at 2-3 (specifying that personal responsibility over health plays an important role in the program). CMS further noted in its initial approval letter that, “[w]ith the approval of this demonstration, CMS is permitting the State to test a model of health coverage that emphasizes private health insurance, personal responsibility, and ‘ownership’ of health care.” Letter from Kerry Weems, Acting Adm’r, Ctr. for Medicare & Medicaid Serv., to E. Mitchell Roob, Sec’y, Indiana Family and Soc. Serv. Admin. (Dec. 14, 2007), [https://www.in.gov/fssa/files/IN\\_-\\_Healthy\\_Indiana\\_Plan\\_\(HIP\).pdf](https://www.in.gov/fssa/files/IN_-_Healthy_Indiana_Plan_(HIP).pdf).

99. *See* 42 U.S.C. § 1315(a) (2020) (permitting states to seek Medicaid demonstration waivers which will promote the objectives of Medicaid; 42 U.S.C. § 1396-1 (2020) (citing to Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L., MED & ETHICS 416, 422 (2004) (stating that a chief purpose of Medicaid is to “furnish medical assistance”).

100. *See, e.g.*, Robin Rudowitz et al., *Medicaid Expansion Waivers: What Will We Learn?*, Kaiser Family Found. (Mar. 1, 2016), <https://www.kff.org/medicaid/issue-brief/medicaid-expansion-waivers-what-will-we-learn/> (discussing “common features” of Medicaid expansion waivers such as “a ‘premium assistance’ model, in which the state uses federal Medicaid funds to purchase Marketplace coverage for enrollees or other private coverage; enrollee premiums; elimination of the non-emergency medical transportation benefit, which is otherwise required under Medicaid; and use of “healthy behavior incentives” to reduce enrollee premiums and/or copayments”).

granted under the Bush administration met a quiet demise rather than being renewed during the first years of the Obama administration.<sup>101</sup> But after *NFIB v. Sebelius*,<sup>102</sup> which made the ACA's expansion of Medicaid to all adults earning no more than 133% of the federal poverty level optional for states, CMS became more willing to grant waivers to states as quid pro quo in exchange for Medicaid expansion.<sup>103</sup> In those cases, CMS justified the waivers on the ground of promoting "health" rather than expansion of coverage, although expansion was likely what CMS actually intended to promote.<sup>104</sup> CMS appeared to favor more extensive coverage at some cost to the integrity and goals of the program, rather than no coverage at all.

The Trump administration followed the Obama administration's lead in using the ostensible rationale of health promotion to serve other purposes regarding Medicaid. However, the Trump administration went in quite a different direction. Rather than seeking to entice reluctant states to expand Medicaid coverage, the Trump administration instead cited health as an ostensible rationale for states to make non-elderly, non-disabled, adult Medicaid beneficiaries satisfy work requirements and other non-health related measures as a condition to retain Medicaid coverage.<sup>105</sup> Early decision letters from CMS approving such requirements cited the benefits they would have on beneficiaries' health and well-being. Such benefits allegedly range from "incentiviz[ing] uptake of preventive health services" to "encourag[ing] beneficiaries to obtain employment and/or undertake other community engagement activities that research has shown to be correlated with improved health and wellness" and "provid[ing] incentives for responsible decision-making."<sup>106</sup> Described in this

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101. See, e.g., Laura Hermer, *On the Expansion of "Welfare" and "Health" under Medicaid*, 9 ST. LOUIS UNIV. J. HEALTH L. & POL'Y 235, 241 (2016) (describing the Obama Administration's actions to reduce the "arguable excess of Section 1115 waivers").

102. Nat'l Fed'n of Indep. Bus. v. Sebelius, 57 U.S. 517 (2012).

103. Hermer, *supra* note 101, at 242-43 (explaining that states would only agree to expand Medicaid if certain conditions were waived, such as the ability to institute personal responsibility requirements).

104. See, e.g., CTR. FOR MEDICARE AND MEDICAID SERVICES, NO. 11-W-00245/5, HEALTHY MICHIGAN SECTION 1115 DEMONSTRATION SPECIAL TERMS AND CONDITIONS, (2013) [hereinafter Michigan Section 1115 Demonstration STCs], [https://www.michigan.gov/documents/mdhhs/Healthy\\_Michigan\\_Plan\\_2nd\\_Waiver\\_STCs\\_12\\_17\\_15\\_5\\_08663\\_7.pdf](https://www.michigan.gov/documents/mdhhs/Healthy_Michigan_Plan_2nd_Waiver_STCs_12_17_15_5_08663_7.pdf) (listing among the demonstration's goals, including to "[e]ncourag[e] individuals to seek preventive care and encourage the adoption of healthy behaviors").

105. See, e.g., Letter from Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dir. (Jan. 11, 2018), <https://www.medicare.gov/federal-policy-guidance/downloads/smd18002.pdf>. "Today, CMS is committing to support state demonstrations that require eligible adult beneficiaries to engage in work or community engagement activities (e.g., skills training, education, job search, caregiving, volunteer service) in order to determine whether those requirements assist beneficiaries in obtaining sustainable employment or other productive community engagement and whether sustained employment or other productive community engagement leads to improved health outcomes." *Id.* at 3.

106. Letter from Demitrios L. Kouzoukas, Principal Deputy Admin., Ctr. for Medicare & Medicaid Serv., to Steven B. Miller, Comm'r, Kentucky Cabinet for Health Servs. 3-4 (Jan. 12, 2018), <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By->

way, CMS has argued that it may be an unfortunate side effect if some, or even many, lose coverage as a result of the requirements, but that it is simply part of the cost of encouraging Medicaid beneficiaries to become more responsible and self-sufficient and allowing states to more productively use scarce resources.<sup>107</sup>

As discussed earlier in the context of wellness programs, the rationale underlying Medicaid waivers also matters. The Obama Medicaid expansion waivers, however much they opened the door to justifying waivers on invalid grounds, did indeed promote the provision of medical assistance.<sup>108</sup> Without them, it is unlikely that a number of Republican-led states would have expanded Medicaid. However, obtaining agreement from states like Indiana, Michigan, and Iowa to expand Medicaid in exchange for permitting the states to curtail non-emergency medical transportation or to lock out some beneficiaries from coverage if they failed to make required monthly contributions from their meager incomes or to take other punitive steps undermines the program's purpose of extending medical assistance to qualifying populations.<sup>109</sup> This is something we are certainly seeing now under the Trump administration. States ought not to hold their most vulnerable populations hostage to ideological priorities, and the federal government ought not to allow them to do this.

The Trump administration's rationale differs dramatically from that of the Obama administration. Under Trump, CMS seeks to use Medicaid, in many cases, like a temporary crutch to help support an individual who is learning to walk again.<sup>110</sup> As the Trump administration would have it, one day, ideally

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Topics/Waivers/1115/downloads/ky/health/ky-health-cms-appvl-011218.pdf (approving Kentucky's demonstration project). These rationales have remained relatively constant to date. See, e.g., Letter from Seema Verma, Admin. Ctr. for Medicare and Medicaid Serv., to Nathan Checketts, Director, Utah Dep't of Health (March 29, 2019), <https://perma.cc/G5Z5-KYMH>. (stating that "[w]ith approval of these amendments to the PCN demonstration, Utah and CMS will be able to evaluate the effectiveness of a policy that is designed to improve the health of Medicaid beneficiaries and promote their financial independence. Promoting beneficiary health and independence advances the objectives of the Medicaid program").

107. See Letter from Seema Verma, Admin. Ctr. for Medicare and Medicaid Serv., to Nathan Checketts, *supra* note 106 at 9 (stating that "CMS acknowledges that some beneficiaries could lose coverage, at least temporarily, for failure to comply with the demonstration's community engagement requirement. However, it furthers the Medicaid program's objectives to allow states to seek innovative means of deploying their limited state resources in ways that may allow them to provide coverage to individuals beyond the statutory minimum...").

108. See The Advisory Board, *Where the States Stand on Medicaid Expansion* (Jan. 13, 2020), <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap> (noting the number of people who gained coverage in each state through the ACA's Medicaid expansion, including the states that accomplished their expansion through a § 1115 waiver).

109. 42 U.S.C. § 1396-1(1).

110. In a 2018 speech, CMS Administrator Seema Verma said,

The problem too often is that the most well-meaning government policies trap people in a hopeless cycle of poverty, making it too difficult to escape, and too easy to become more dependent. Instead, we ought to insist that the able-bodied participate in earning benefits. To quote from Arthur [Brook]'s book, *The Conservative Heart*: 'Work gives people something

sooner than later, the individual will be able to throw the crutch of Medicaid away and walk on his own. If she or he is unable to do so, the crutch may be removed.<sup>111</sup>

## PART II: SOME ETHICAL AND PRACTICAL PROBLEMS WITH WORKPLACE WELLNESS PLANS AND MEDICAID PERSONAL RESPONSIBILITY REQUIREMENTS

The difference in the ends sought, respectively, by the Obama administration and the Trump administration matter: The Obama administration simply sought to encourage Medicaid expansion by states that would likely otherwise have refrained from doing so; the Trump administration, on the other hand, is seeking to both fundamentally change and diminish the program itself.<sup>112</sup>

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welfare never can. It's a sense of self-worth and mastery, the feeling that we are in control of our lives. This is a source of abiding joy. There's a reason that Aristotle wrote "happiness belongs to the self-sufficient." ... It's easier to give someone a hand, it's much harder to build a ladder to help people climb their way out of poverty. But even though it is harder, it's the right thing to do.

CTR. FOR MEDICARE AND MEDICAID SERVICES, *Remarks by Administrator Seema Verma at the 2018 Medicaid Managed Care Summit* (Sept. 27, 2018), <https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-2018-medicare-managed-care-summit>. The Trump administration was more explicit in its Memorandum in Support of Defendants' Motion to Dismiss or, in the alternative, Motion for Summary Judgment in *Stewart v. Azar*, in which it defended Secretary Azar's approval of Kentucky's KY HEALTH Medicaid demonstration project: "Although plaintiffs call it a simple benefits cut, KY HEALTH is not designed to withdraw health insurance coverage from vulnerable people. Rather, it is designed (in part) to help people transition, or graduate, to commercial coverage." *Stewart v. Azar*, Civil Action No. 1:18-cv-15, Memorandum in Support of Defendants' Motion to Dismiss or, in the alternative, Motion for Summary Judgment 24 (Apr. 25, 2018), [https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.51.1\\_1.pdf](https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.51.1_1.pdf).

111. For example, CMS describes the community engagement requirement in the Healthy Indiana Plan as follows:

Indiana will implement a community engagement requirement as a condition of eligibility for HIP beneficiaries, with exemptions for various groups, including: pregnant women, beneficiaries considered medically frail, members in active substance use disorder (SUD) treatment, and students. To remain eligible, non-exempt beneficiaries must complete a specific number of hours per week of community engagement activities, such as employment, education, job skills training, and community service for eight months in the 12-month calendar year. Beneficiaries will have their eligibility suspended in the new calendar year for failure to demonstrate compliance with the community engagement requirement during the prior calendar year. During an eligibility suspension, beneficiaries may reactivate their eligibility in the month following notification to the state that they completed a calendar month of required hours. Indiana will provide good cause exemptions in certain circumstances for beneficiaries who cannot meet requirements.

CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00296/5, HEALTHY INDIANA PLAN, 2 (2018) <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-cms-amend-appvl-02012018.pdf> [hereinafter Healthy Indiana Plan STCs].

112. See e.g., CTR. FOR MEDICARE AND MEDICAID SERVICES, SMD 20-001, HEALTHY ADULT OPPORTUNITY, 1-3, 5-11, 16-25 (Jan. 30, 2020), <https://www.medicare.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf> (inviting states to submit "Healthy Adult Opportunity" waiver applications that would cap a state's federal Medicaid matching funds in exchange for substantial

But the means, in both cases, undermine the program. The purpose of Medicaid, as enacted, is to allow states as far as practicably possible to furnish medical assistance to certain qualifying individuals.<sup>113</sup> Congress nowhere cited health improvement in describing the program's purpose.<sup>114</sup> Nevertheless, the Obama administration used this rationale in approving waivers sought by conservative states wanting to impose personal responsibility requirements as a condition of expanding Medicaid.<sup>115</sup> The approval process for § 1115 waivers, especially prior to the ACA, has not been characterized as transparent.<sup>116</sup> By unmooring the § 1115 waiver process even further from its already amorphous and opaque statutory roots, the Obama administration arguably made it easier for the Trump administration to justify its approval decisions.<sup>117</sup> While CMS, under the Obama

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state flexibility to impose work requirements, change or limit benefits, impose cost-sharing, and change eligibility standards without seeking advance federal approval).

113. 42 U.S.C. § 1396-1.

114. *See id.*

115. *See* Michigan Section 1115 Demonstration STCs, *supra* note 104, at 3 (highlighting as a state goal to encourage “individuals to seek preventative care and encourage the adoption of healthy behaviors”); CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00296/5, HEALTHY INDIANA PLAN 2.0, 2 (2015) [https://secure.in.gov/fssa/hip/files/HIP\\_CMS\\_Approved\\_STC\\_Technical\\_Corrections\\_5.14.15.pdf](https://secure.in.gov/fssa/hip/files/HIP_CMS_Approved_STC_Technical_Corrections_5.14.15.pdf) (listing as a goal to encourage “healthy behaviors and appropriate care, including early intervention, prevention, and wellness”) [hereinafter Indiana Section 1115 Demonstration STCs 2.0]; CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00295, HEALTHY PENNSYLVANIA 2 (2014), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-ca.pdf> (noting that “With this demonstration Pennsylvania proposes to further the objectives of title XIX by ... Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness”) [hereinafter Pennsylvania Section 1115 Demonstration STCs]; CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00275/9, 21-W-00064/9, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM—AHCCCS, A STATEWIDE APPROACH OF COST EFFECTIVE HEALTH CARE FINANCING 2 (2011) (observing that “[t]he demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups”) [hereinafter Arizona Section 1115 Demonstration STCs].

116. *See, e.g.,* Sidney Watson, *Out of the Black Box and into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 213 (2015) (highlighting issues of transparency within the Section 1115 Waiver process). “As the size and number of Section 1115 waivers have grown, so have concerns about the lack of transparency in the waiver approval process. Section 1115 Medicaid waiver requests have typically been negotiated behind closed doors: demonstration goals were often not clearly stated, the terms of the waivers were sometimes vague, and evaluations of demonstrations were often either not done, or not shared with the public or HHS.” *Id.* at 214-15.

117. For example, in its Memorandum in Support of Defendants' Motion to Dismiss or, in the alternative, Motion for Summary Judgment in *Stewart v. Azar*, the Department of Justice observed that “[t]he approval of these incentives hardly represents a sea change in the Administration's position, as plaintiffs suggest. In its waiver application, the Commonwealth noted that ‘most of the features of Kentucky HEALTH’ had been approved in other State demonstrations ... , and the results of the other demonstrations informed Kentucky's project design. For example, during the last Administration, CMS approved a provision for suspension of coverage for Indiana's demonstration known as HIP 2.0. ... That project permitted the State to impose disenrollment and a non-eligibility period for beneficiaries with income over the federal poverty level who fail to pay their premiums, as an incentive to promote

administration, is hardly the primary entity responsible for the actions of CMS, under the Trump administration, the former must bear at least a small part of the blame for what has happened under the latter. Even an ethically “good” end should not be pursued using means that may be unlawful and that damage already tenuous norms.<sup>118</sup>

There are consequences to shifting greater responsibility onto individuals for ensuring that the parameters of their lives are as healthy as possible. As others have noted, programs seeking to persuade or pressure individuals to take greater measures to improve their health carry real potential to unduly burden comparatively disadvantaged populations.<sup>119</sup> Individuals with fewer resources often have diminished ability to affect their circumstances. It is not at all clear with respect to such programs where one should draw the line between what is freely chosen and what is determined by forces outside the participants’ control. Yet participants are penalized for both.

Take, for example, Medicaid personal responsibility requirements. While states were largely prevented under the Obama administration from doing other than offering rewards for behaviors deemed by the state to be “healthy,” under the Trump administration states have unprecedented freedom to penalize beneficiaries or even take away their Medicaid coverage for failing to achieve certain health or “personal responsibility” goals implemented under certain state

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program compliance.” Memorandum in Support of Defendants’ Motion to Dismiss, *supra* note 110 (internal citation omitted).

118. *See, e.g.*, *Stewart v. Azar*, 366 F.Supp.3d 125, 131 (D.D.C. 2019) (discussing Kentucky’s pursuit of approval of a program that would likely cause “nearly 100,000 people to lose coverage,” threatening to end coverage completely if the program was not approved). “Defendants urge the Court to adopt the proposition that the Secretary need not grapple with the coverage-loss implications of a state’s proposed project as long as it is accompanied by a threat that the state will de-expand – or, indeed, discontinue all of Medicaid. By definition, so this argument goes, any number of people covered by an experimental Medicaid program would be greater than the number if there were no Medicaid at all; as a result, any demonstration project that leaves any individual on a state’s Medicaid rolls promotes coverage. The Court cannot concur that the Medicaid Act leaves the Secretary so unconstrained, nor that the states are so armed to refashion the program Congress designed in any way they choose.” *Id.*

119. *See, e.g.*, Wendy Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 DUQ. L. REV. 271, 325 (2012) (explaining that the target population for wellness program typically coincides with lower socioeconomic groups already burdened with higher prevalence of chronic diseases and other health concerns). “About half of those with disabilities who work earn poverty-level wages. While it might seem helpful to create financial incentives for them to reduce their health risks, they may be in the weakest position to do so. If these individuals do not succeed in qualifying for discounts or rewards, they will pay a larger share of their smaller income to obtain the same health insurance available to everyone else in the pool. In the worst case, they will not find employment at all, yet income can be a better predictor of health than the health factors that wellness programs seek to improve.” *Id.*; *see also* Jessica Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571, 607 (2014) (arguing that “employer screens for health could disproportionately harm certain vulnerable populations, in particular racial and ethnic minorities, people with disabilities, and the poor and near-poor by simultaneously restricting their access to wage work and to employer-provided benefits.”).

§ 1115 waivers.<sup>120</sup> As just one example, this led in Arkansas to over 18,000 individuals losing their Medicaid coverage in 2018 because they failed to verify compliance with the state's work requirement, which the state imposed on some beneficiaries as an ostensibly "healthy" behavior.<sup>121</sup> It is unclear whether these individuals failed because they had no access to a computer in initial months to verify compliance, or because they did not know about or understand the requirement, or had limited opportunities available to them, or could work but simply did not want to do so. One study, however, found that more than 95% of the study population subject to the work requirements were either already meeting them or should have qualified for an exemption, and that nearly 35% had never even heard of the requirements.<sup>122</sup>

Health-contingent wellness programs can create similar binds. They take a more paternalistic approach to personal health by offering benefits to - or imposing penalties upon - individuals based on their achievement, or lack thereof, of certain health goals, activities, or biometric indicators.<sup>123</sup> One program, for example, gives employees the option of undergoing an annual biometric screening through a third-party vendor to measure factors such as body mass index, blood pressure, cholesterol and tobacco/nicotine use, using an online risk assessment, and participating in a variety of workplace fitness activities, or else be subject to a weekly health premium surcharge of \$50.<sup>124</sup> Such programs assume a causal connection between individual actions and measured outcomes and reward or penalize participants based on the results. Employers oftentimes describe a primary impetus for such programs as reducing health care costs, often

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120. See, e.g., Healthy Indiana Plan STCs, *supra* note 111, at 23-24 (describing penalties, including disenrollment, for non-payment of POWER account contributions); CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00293/5, WISCONSIN BADGERCARE REFORM, 23 (2018) <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf> (describing how beneficiaries with a health risk behavior such as "excessive alcohol consumption, failure to engage in dietary, exercise, and other lifestyle (or "healthy") behaviors in attempt to attain or maintain a healthy body weight, illicit drug use, failure to use a seatbelt, and tobacco use" who fail either to attest that they are actively managing their behavior or that they have a condition that causes them to engage in that behavior will be charged a full premium for coverage rather than a reduced one); CTR. FOR MEDICARE AND MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, No. 11-W-00275/9, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, 27 (2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf> (specifying disenrollment as a penalty for failing to pay a monthly "premium" to their medical spending account).

121. ARK. DEP'T OF HUMAN SERVS., ARKANSAS WORKS PROGRAM 8 (2018), [https://humanservices.arkansas.gov/images/uploads/011519\\_AWRReport.pdf](https://humanservices.arkansas.gov/images/uploads/011519_AWRReport.pdf).

122. Benjamin D. Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 HEALTH AFFAIRS 1522, 1526, 1527 (2020).

123. See *supra* notes 27-28 and accompanying text.

124. RAND Corporation, *Workplace Wellness Programs Study 52-54* (2013), <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/analysis/health-and-welfare/workplace-wellness-programs-study-case-studies-summary-report.pdf>.

by incentivizing healthy choices or disincentivizing unhealthy ones.<sup>125</sup> Yet, as Professor Wikler observes, employees may have only limited freedom of choice in their ability to participate in such programs, depending on a host of circumstances.<sup>126</sup> In cases where better health choices might be “less attractive than they should have been, morally speaking,” or where they are effectively unavailable, then the terms on which an individual makes an unhealthy choice may be unfair in a real, moral sense.<sup>127</sup> Such individuals may be penalized not only in the constraints they may face in making such choices and the adverse health consequences that may result, but also in the penalties exacted through certain wellness programs.<sup>128</sup>

At the same time that governments and employers are reallocating responsibility for health onto individuals, to the arguable detriment of the most disadvantaged among them, some of these same governments are making it more difficult for individuals to make healthy choices about basic conditions of their existence, such as the water they drink and the air they breathe.<sup>129</sup> Before the government can hold individuals accountable for their own health, it needs to do its part to ensure the existence of necessary preconditions for living a healthy life. A person can exercise, eat a reasonable diet, and not smoke or drink, but if they live in a part of the country where oil refining facilities regularly vent

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125. See, e.g., Dee Edington, *Workplace Wellness Programs: a Win-Win Strategy*, in U.S. CHAMBER OF COMMERCE, WINNING WITH WELLNESS 13, 13-15 (2019), [https://www.uschamber.com/sites/default/files/022436\\_labr\\_wellness\\_report\\_opt.pdf](https://www.uschamber.com/sites/default/files/022436_labr_wellness_report_opt.pdf) (discussing the benefits employers could see in reducing health care costs and providing several examples of several companies' experiences).

126. See Wikler, *supra* note 1, at 99-101 (discussing whether various people truly do have the freedom to make lifestyle choices that will improve health).

127. Wikler, *supra* note 1, at 101.

128. See *supra* note 32 and accompanying text.

129. See, e.g., Jim Malewitz & Kiah Collier, *To Paxton's Cheers, Court Blocks EPA Clean Water Rule*, TEXAS TRIBUNE (Oct. 9, 2015), <https://www.texastribune.org/2015/10/09/paxtons-cheers-court-blocks-epa-clean-water-rule/> (reporting a stay of the Obama-era Clean Water Rule in response to a challenge brought by Ohio, Texas and other states); see also Charles Piller, *Exclusive: FDA Enforcement Actions Plummet Under Trump*, SCIENCE MAGAZINE (Jul. 2, 2019), <https://www.sciencemag.org/news/2019/07/exclusive-fda-enforcement-actions-plummet-under-trump> (noting that FDA warning letters have fallen by one-third and that warnings from the FDA Center for Devices and Radiological Health dropped by more than two-thirds); Michael Hawthorne, *Under Trump, the EPA Has Cut Back on Enforcement of Clean Water Laws in the Great Lakes Region*, CHICAGO TRIBUNE (Apr. 21, 2020), <https://www.chicagotribune.com/news/environment/ct-trump-epa-great-lakes-enforcement-decline-20200421-ddrijfviyrchpa2khe6za5d5m4-story.html> (describing the substantial downturn in EPA enforcement actions under the Trump administration against plants that, for example, dumped carcinogenic or toxic substances into lakes and rivers); Richard Florida & Claire Tran, *Where Americans Lack Running Water, Mapped*, BLOOMBERG CITYLAB (Aug. 6, 2019), <https://www.bloomberg.com/news/articles/2019-08-06/where-americans-lack-running-water-mapped> (describing how “plumbing poverty is clearly linked to race and ethnicity,” and is also associated with poverty and renter rather than homeowner status); Bill Lindeke, *Sidewalks Are Public Health*, STREETS.MN (Apr. 20, 2020), <https://streets.mn/2020/04/20/sidewalks-are-public-health/> (discussing the dangerousness and inadequacy of sidewalks in locations throughout the Twin Cities in Minnesota).



benzene and other pollutants above legal thresholds,<sup>130</sup> or where steel mills dump carcinogenic metals into drinking water sources with relative impunity,<sup>131</sup> they cannot be said to have full and meaningful responsibility for their health. To blame individuals for bad health outcomes under such circumstances is the antithesis of personal responsibility, in which individuals choose their own goals and accept the consequences.<sup>132</sup>

While individuals are being penalized by making what employers or states consider to be poor health choices, many industries are largely free to market unhealthy products that are designed and produced with the specific goal of maximally enticing their use or consumption by these same people.<sup>133</sup> We subsidize production of corn and soybeans<sup>134</sup> – the primary ingredients for many calorie-laden but low-nutrient, highly-processed foods, among other items – but not, typically, vegetables and fruit.<sup>135</sup> This policy choice has contributed to a

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130. See, e.g., Kiah Collier, *Report: Six Texas Oil Refineries Spewing Cancer-Causing Pollutant Above Federal Threshold*, TEXAS TRIBUNE (Feb. 6, 2020), <https://www.texastribune.org/2020/02/06/six-texas-oil-refineries-spewing-cancer-causing-pollutant-benzene/> (reporting that six refineries in Texas had concentrations of benzene over the legal threshold at their fence lines, including three in the Houston area).

131. See Hawthorne, *supra* note 129 (reporting that U.S. Steel “reported another spill of hexavalent chromium six months later, around the same time public interest lawyers dug up records documenting scores of other clean water violations at the northwest Indiana steel mill. Yet Trump appointees at the U.S. Environmental Protection Agency declined to punish the company, rebuffing career staff who confirmed U.S. Steel had repeatedly, and illegally, released harmful pollution into the region’s chief source of drinking water”).

132. See, e.g., Frank Nullmeier, *Personal Responsibility and Its Contradictions in Terms*, 3 GERMAN POL’Y STUDIES 386 (2006) (explaining government actions taken under the assumption it knows better than its citizens and denies people of personal responsibility). See also Daniel Wikler, *Personal and Social Responsibility for Health*, 16 ETHICS AND INT’L AFFAIRS 47, 50 (2002) (highlighting that “[t]he same freedom that permits us to act on our personal tastes and preferences, pursuant to our individual goals, plans, and values, reduces the scope of excuses for these choices should they turn out badly. Just as we expect to be left alone to decide which risks to take, others expect to hold us accountable for the consequences, and when they do, in this view, justice is served, not denied”).

133. See, e.g., ERIC SCHLOSSER, *FAST FOOD NATION: THE DARK SIDE OF THE ALL-AMERICAN MEAL*, 120-29 (2002) (describing the role of the flavor industry in creating products designed to maximally appeal to human taste); see also RICHARD KLUGER, *ASHES TO ASHES* 742-47 (1997) (describing how tobacco industry manipulated nicotine levels and availability in cigarettes).

134. See, e.g., *United States Farm Subsidy Information*, ENVIRONMENTAL WORKING GROUP (2018), <https://farm.ewg.org/region.php?fips=00000&progcode=total&yr=2018> (showing that nearly half of the \$18 billion in farm subsidies paid in 2018 subsidized the production of soybeans and corn); see also Caroline Franke et al., *Agricultural Subsidies and the American Obesity Epidemic*, 45 AM. J. PREVENTIVE MED. 330 (2013) (showing subsidy allocation in 2010).

135. See, e.g., CRS, *The U.S. Trade Situation for Fruit and Vegetable Products* 1 (2016), <https://fas.org/sgp/crs/misc/RL34468.pdf> (noting that, “[h]istorically, fruit and vegetable crops have not benefitted from the federal farm support programs traditionally included in the farm bill, compared to the long-standing support provided to the main program commodities (such as grains, oilseeds, cotton, sugar, and milk”); see also Franke et al., *supra* note 134, at 329 (noting that “[f]armers are penalized for growing ‘specialty crops’ (such as fruits and vegetables) if they have received federal farm payments to grow other crops. In other words, federal farm subsidies promote unsustainable agriculture while also failing to reward good stewardship. Further, although farmers may generate higher marketplace revenue

growing disparity between the comparatively cheap cost of commodity products and comparatively healthier fresh fruits and vegetables,<sup>136</sup> to the arguable detriment of people's health.<sup>137</sup> States and private developers are relatively free in some jurisdictions to design communities in ways that ignore or foreclose reasonable opportunities for residents to exercise, associate easily and comfortably with one another in person, and enjoy peaceful, green spaces.<sup>138</sup> If we want individuals to avoid indolence, gluttony, and misuse of intoxicating substances, why do we penalize them for such behaviors, while at the same time giving largely free rein to industries to promote that behavior? If we actually cared about the health and well-being of individuals, we would make it easier for them to buy and make healthy food, live in pleasant, reasonably safe, and well-designed neighborhoods with plenty of opportunities for recreation, and foster vibrant communities where curiosity is encouraged and where people have multiple opportunities to connect and become involved, in an effort to build strong societies and improve mental health. But, we do not. We instead allow individuals to be treated as a means of maximizing profit, rather than as ends unto themselves. One can say that they are used as raw materials in commerce, and then punished when they behave as they are directed.

This is not surprising, but still unacceptable. It is far easier to put the onus of health improvement on individuals, particularly impoverished or otherwise disadvantaged individuals, rather than addressing the underlying social determinants of health and structural inequalities that precipitate poor health.<sup>139</sup> With the current attention paid to prevention, linking health care and coverage to the state of being healthy seems almost natural. What is more, health care and coverage are perennially well-positioned to absorb ever-increasing spending

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from fresh produce, substantially lower economic security makes growing fruits and vegetables a risky proposition in an already risky industry"). *But see* Julian M. Alston et al., *Farm Subsidies and Obesity in the United States: National Evidence and International Comparisons*, 33 *FOOD POL'Y* 470 (2008) (finding that the farm programs, commodity prices, and the implications of farm policies have negligible impacts upon consumers dietary patterns and obesity).

136. *See, e.g.*, Franke et al., *supra* note 134, at 331 (arguing that a "redesign of the subsidy system [to prioritize sustainable, biodiverse crops], rather than its elimination, is likely to yield more sustainable changes in the agricultural industry. Such revision could take the form of decoupling income supports from program-specific crops, and rewards for agricultural diversification"); *see also* Pablo Monsivais et al., *The Risking Disparity in the Price of Healthful Foods*, 35 *FOOD POL'Y* 514 (2010) (highlighting growing concerns with nutritional content of the American diet).

137. *See, e.g.*, Franke et al., *supra* note 134, at 328 (arguing that "American farm policy is effectively driving the production and propagation of cheap sugars and oils that lead to widespread weight gain.").

138. *See, e.g.*, Andrew Chee Keng Lee et al., *Value of Urban Green Spaces in Promoting Health Living and Wellbeing: Prospects for Planning*, 8 *RISK MGMT. AND HEALTH CARE POL'Y* 131 (2015) (discussing the use of green spaces to combat obesity and mental illness).

139. *See, e.g.*, Simon Szreter, *The Population Health Approach in Historical Perspective*, *AM. J. PUB. HEALTH* 421 (2003) (discussing historical perspectives of health systems along with the "resurgence of the population health approach [which] has developed from dissatisfaction with some of the limitations of a strongly individual-oriented methodology").

because of their substantial subsidization by government. Health care provides an easy out for both government and society regarding health improvement. It is far easier to tell someone to take a pill or have a surgery than it is to either prevent or ameliorate their health problem by diminishing pollution and encouraging both exercise and healthier eating through structural changes in society.

The outcome might be different if evidence demonstrated that imposing the burden of health improvement more heavily on individuals than on structural or societal elements yielded the best outcomes. If it were more effective and less expensive to focus efforts on individuals rather than to alter our regulation of certain industries, then it might be justifiable to require individuals to adhere to wellness programs or otherwise make efforts to demonstrate their personal responsibility for health as a condition of accessing benefits or obtaining them more cheaply.

Unfortunately, no definitive evidence exists to support this. With respect to wellness programs, existing evidence suggests that such programs yield only limited, if any, benefits, regardless of whether one examines changes in health or reductions in overall health care costs.<sup>140</sup> Evidence suggests that wellness

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140. In the case of wellness requirements, participation rates among employees can be quite variable. On average, slightly less than half take advantage of a health risk assessment or other health screening if offered, but participation rates vary substantially from employer to employer. Soren Mattke et al., *Workplace Wellness Programs Study: Final Report* 36 (RAND 2013), [https://www.rand.org/content/dam/rand/pubs/research\\_reports/RR200/RR254/RAND\\_RR254.pdf](https://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf). Participation in health-contingent wellness programs is even less. Sixty-five percent of employer's report that only 20% or fewer of their employees participate in any health-contingent program. *Id.* at 37. That percentage rises to 90% of employers with 20% or less participation in the case of weight or smoking management programs. *Id.* In a case study of five large employers (each having between 3,500 and 65,000 employees) that RAND performed in 2009, one employer had participation from a substantial majority (86%) of its employees, however the other firms only recorded about 25% - 55% of their employees participating in any wellness program component, whether participatory or health-contingent. *Id.* at 40. Adding a weekly \$50 premium surcharge appeared to be the primary impetus for the increased participation at one case study workplace. *Id.* at 59. Exercise programs had a significant effect according to the RAND report. Participants added an extra 1.5 days per week during which they exercised at least 20 minutes per day. *Id.* at 44. The results were significant in the first and second years of the study, but not as strong thereafter. *Id.* Among smokers who participated in a workplace smoking cessation program, nearly 30% more stopped smoking in the first year than among non-participant smokers. *Id.* at 45. The effect continued, though at lesser rates, over time. *Id.* To put it in perspective, 33 smokers at one of the participating case study employers quit smoking between 2011 and 2012, for a total reduction in the percentage of smokers at the firm of 1%. *Id.* at 46. Weight reduction studies had perhaps the least impact, although it was still statistically significant. The overweight or obese employees who participated in such a program (11% of such employees, on average, across the five employers) had a 0.15 point reduction in BMI in the first year of the program and less thereafter. This translated to less than one pound per woman who stood 5'4" and weighed 165 pounds, and nearly one pound per man who stood 5'9" and weighed 195 pounds. *Id.* at 47. While RAND found cost savings between participants and non-participants, the savings did not reach the level of statistical significance. *Id.* at 55-57. That being said, studies have found that employers who offer wellness plans do so primarily to reduce costs – their own costs. *See, e.g.,* Nat'l Bus. Group on Health, *Making Well-Being Work: Ninth Annual Employer-Sponsored Health and Well-Being Survey* 1 (Fidelity Investments 2018),

programs may, at least in some cases, yield cost savings.<sup>141</sup> However, as suggested earlier, these benefits may largely exist only for healthy employees participating in health-contingent wellness programs and their employers, and only because their costs may be shifted in part onto less healthy, often lower-income employees.<sup>142</sup> The evidence for the efficacy of personal responsibility programs in Medicaid is even more scant. Little evidence exists whether one considers relatively novel work requirements<sup>143</sup> or longer-standing punitive measures regarding cost sharing, benefit reductions or lockout periods for failures to meet specific targets.<sup>144</sup>

Placing an undue onus on individuals to make and keep themselves healthy, without adequate social and governmental support, is not only ethically unsound but also has little evidentiary support. It is time to end the current trend toward

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[https://www.fidelity.com/bin-public/060\\_www\\_fidelity\\_com/documents/press-release/Fidelity-Well-Being-Survey-041819.pdf](https://www.fidelity.com/bin-public/060_www_fidelity_com/documents/press-release/Fidelity-Well-Being-Survey-041819.pdf) (describing the incentive employers have to implement well-being programs).

141. See, e.g., U.S. CHAMBER OF COMMERCE, *supra* note 125, at 14-15 (discussing return on investment for specific employers).

142. See Jill Horwitz et al., *supra* note 72, at 474 (explaining that the “review found, at best, conflicting evidence that people with the conditions typically included in wellness programs spend more on health care than others and, therefore, offer particularly attractive sources for cost reduction; respond to financial incentives with behavior changes; and thus improve their health. How can these findings be reconciled with claims that wellness programs have reduced employers’ costs? ... [T]he evidence makes it quite plausible that employees with health risks are paying more for their care, subsidizing the healthy employees in the programs.”).

143. Ark. Dep’t of Human Servs, *Arkansas Works Section 1115 Demonstration Waiver: 2018 Annual Report* 7, 12 (2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf>; Arkansas’s Arkansas Works annual report stated that, out of the 38,321 individuals subject to work requirements who were required to report their work activities, 4,353 failed to comply for three months and thus were disenrolled from the program. *Id.* See also Indiana Family & Soc. Servs. Admin., *Learn about Gateway to Work*, [https://ismanet.org/ISMA/Resources/e-Reports/12-5-18/HIP\\_members\\_will\\_learn\\_their\\_work\\_requirement\\_status\\_by\\_Dec\\_10.aspx](https://ismanet.org/ISMA/Resources/e-Reports/12-5-18/HIP_members_will_learn_their_work_requirement_status_by_Dec_10.aspx) (explaining that Indiana has also implemented an approved work requirement; however, it commenced in January 2019 and no data is yet available with respect to it).

144. See, e.g., Lewin Group, *Healthy Indiana Plan 2.0: Power Account Contribution Assessment* 1, 7-8, 10-12 (2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf> (finding that, of the 590,315 HIP participants eligible to make a “POWER” account contribution in 2015-2016, and thus to enroll in or remain enrolled in HIP Plus, 55% failed to do so during that time period, resulting in their demotion to HIP Basic, their disenrollment, or their non-enrollment. The total included nearly 30% of those who earned 100% or more of the federal poverty level, and thus who could be either disenrolled or never enrolled in HIP as a result of failure to pay into their POWER account). Indiana paused implementation of its 6-month lockout policy in October, 2018. CMS, *Medicaid Section 1115 Monitoring Report Indiana –Healthy Indiana PlanDY4 Annual Report* 5 (Mar. 26, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-dy4-20190411.pdf>. There were “no discernable patterns” in emergency department use between HIP beneficiaries who were directed to pay a higher copayment (\$25 versus \$8) for non-emergent use of the emergency department, and those who were charged a flat fee (\$8) for any ED use. Lewin Group, at 32.

imposing personal responsibility requirements on individuals, and instead to share more broadly the burdens of creating healthy communities.