

Senate Amendment on Wellness Program Surcharges Jeopardizes Access to Affordable Coverage and Care

Summary

Currently, federal HIPAA rules allow group health insurance plans to modify premiums and cost-sharing by up to 20 percent of the value of a member's total premium based on whether or not that member reaches a wellness goal, such as lowering cholesterol or decreasing body mass index (BMI). Under these rules, consumers may be subject to significant increases in their health care costs—increases that can make coverage or care much less affordable.

Furthermore, there is no appeals process in place for participants who receive wellness plan penalties that they do not think they deserve. For example, if a participant's doctor tells him that his BMI is 34—just under his employer wellness plan limit of 35—but he still receives a 20 percent premium increase based on his BMI, he currently has no formal rights to appeal this unfair surcharge. There is also no requirement that the wellness plans imposing such surcharges be based on scientific evidence; therefore, there is no way of knowing if they are even capable of improving participants' health.

An option under consideration in the Senate would allow premium surcharges or increases in cost-sharing—based on the achievement of wellness goals—of 30 percent, with a later increase of up to 50 percent of the value of a participant's insurance premium. This option should be voted down, as it presents a threat to the ability of consumers, especially those who have low incomes or serious health problems, to obtain the care they need at an affordable price.

Talking Points

- Wellness surcharges threaten the family budgets of low- and moderate-income families. The proposed 50 percent surcharge would have amounted to about \$2,400 for a typical individual's premium in a group plan last year—that's more than one-fifth of the total annual income for an individual at the federal poverty level. When low- or moderate-income people have to pay such a surcharge, it affects their whole family, not just the person who is participating in the wellness plan. It leaves less money for housing, food, and clothing for the entire family.
- Increasing consumer health costs decreases the likelihood that people, particularly those with low incomes, will obtain necessary care. Even relatively small increases in copayments lead low-income people to forgo necessary services or prescriptions. The proposed wellness plan surcharges on premiums and cost-sharing would create a difficult and sometimes insurmountable barrier for low-income people seeking health care.

- Low-income people are at a disadvantage in wellness programs that use penalties or rewards, whether they are based on actual health changes (blood pressure, weight, etc.) or just on participation. This is true for two reasons: First, low-income Americans are more likely to have the health conditions that so-called wellness plans target and are therefore more likely to be affected by wellness surcharges. Second, barriers to healthy living—a lack of affordable healthy foods and safe exercise spaces in low-income neighborhoods—and the expense entailed in taking time away from work or children, can make it difficult for low-income people to participate in wellness programs.
- Racial and ethnic minorities may be disproportionately affected by premium surcharges for failure to adhere to wellness goals because they disproportionately suffer from hypertension, high, and other problems that wellness programs typically target.
- People with chronic diseases, mental illnesses, or disabilities may be unable to meet wellness goals for medical reasons. Current rules state that such individuals must be granted an alternative way to participate in wellness plans if standard wellness goals are too difficult or risky for them, but to qualify for such an alternative standard, individuals must navigate a lot of red tape.
- The methods used to monitor achievement in wellness programs can be very invasive of employee privacy. Workers are often subjected to blood tests, urine tests, cheek swabs, and other intrusive tests by their employers, making them uncomfortable and even concerned about discrimination. However, if their only other option is to face health care costs that are up to 50 percent higher, many workers will feel forced to submit to these invasive tests.
- Most employer wellness programs that charge people higher costs for failure to achieve health goals are not based on medical or scientific evidence. Therefore, it is unknown whether or not such programs are capable of improving the health of participants. It is unfair to force people to pay more through a program that has not proven effective in improving health.
- Differential pricing of coverage based on wellness goals conflicts with the larger health reform objective of eliminating insurance discrimination based on health status and pre-existing conditions. Wellness plans allow employers to charge workers with health problems more than their coworkers for the same insurance coverage. Therefore, wellness plans serve as a loophole that lets employers and insurers evade other rules intended to eliminate inequities in access to quality, affordable coverage.



1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005

Phone: 202-628-3030 ■ E-mail: info@familiesusa.org

www.familiesusa.org