Health Care Reform and Wellness Programs

C. Health Status Nondiscrimination and Wellness Programs

Group health plans and health insurance issuers offering health insurance coverage are prohibited from discriminating against an individual with regard to eligibility or coverage based on a health status-related factor.[16] As of January 1, 2014, health care reform[17] extended this nondiscrimination requirement to health insurance issuers offering individual health insurance coverage.[18] See Section V for more on what plans and insurers must comply. Grandfathered health plans are not required to comply.[19] See Section VI for more on grandfathered health plans.

What Are Health-Status Related Factors? The following are health status-related factors:

- health status;
- medical condition (including both physical and mental illnesses);
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability (EOI) (including conditions arising out of acts of domestic violence);
- disability; and
- any other health status-related factor determined appropriate by the Secretary of HHS.*

The last "catch-all" category was added under health care reform.†

* Code § 9802(a)(1); ERISA § 702(a)(1); PHSA § 2705(a).

† PHSA § 2705(a), as added by PPACA, Pub. L. No. 111-148, § 1201(4) (2010).

The prohibition against discriminating based on a health status-related factor means, among other things, that plans and insurers may not charge individuals different premiums or impose different costs based on the presence or absence of a health status-related factor. However, nondiscrimination provisions were not meant to prevent a group health plan or insurer from establishing premium discounts or reduced co-payments or

---

16 Code § 9802; ERISA § 702; PHSA § 2705. PHSA § 2705 was added by PPACA, Pub. L. No. 111-148, § 1201(4) (2010).

17 Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010) (HCERA).

18 PHSA § 2705(a), as added by PPACA, Pub. L. No. 111-148, § 1201(4) (2010). The effective date for this provision is found at PPACA, Pub. L. No. 111-148, § 1255 (2010).

19 See PPACA, Pub. L. No. 111-148, § 1251(a) (2010).

© 2012 Thomson Reuters/EBIA

deductibles in return for "adherence to programs of health promotion and disease prevention."[20] Thus, certain programs of health promotion or disease prevention (referred to as "wellness programs") are an exception to the general prohibition on discrimination based on a health status-related factor. As discussed in this subsection C, the intent under health care reform seems to be toward expansion of such programs—but specific legal hurdles remain (such as compliance with the ADA).

1. What Is a Wellness Program?

Workplace wellness programs can take many forms, and may not even be called "wellness programs." A comprehensive wellness program can include, among other features, health-related communications, health risk assessments, and rewards (or penalties) intended to raise employees' health awareness and promote healthy lifestyles. Wellness programs can cover only employees, or can also cover employees' spouses and other family members. The common goal of most workplace wellness programs is to help control health plan costs.

For more information about the design and operation of wellness programs, see Section VI of *Consumer-Driven Health Care* (Thomson Reuters/EBIA, 2004-present, updated quarterly).

2. Which Wellness Programs Are Exempt From Nondiscrimination Requirements?

Health care reform codified the 2006 HIPAA regulations' nondiscrimination requirements for wellness programs, without significant changes apart from, as discussed below, an increase in the maximum permissible reward. The codified rules are effective for plan years beginning on or after January 1, 2014.[21] In June 2013, the IRS, DOL, and HHS issued final regulations addressing changes relating to employee wellness programs under health care reform.[22] The final regulations, which amend existing wellness regulations issued in 2006 under HIPAA, apply to insured and self-insured group health plans (both grandfathered and non-grandfathered), effective for plan years beginning on or after January 1, 2014. They largely retain key elements of the proposed regulations (issued in November 2012), including an increase in the maximum permissible reward under a health-contingent wellness program from 20 to 30% of the cost of individual coverage under the group health plan, and up to 50% for programs designed to prevent or reduce tobacco use. As discussed below, clarifications have been made about what constitutes a reasonable design for health-contingent wellness programs (distinct from participatory wellness programs), and the reasonable alternatives these programs must offer in order to avoid prohibited discrimination. The final regulations also distinguish between two types of health-contingent wellness programs—"activity-only" wellness programs and "outcome-based" wellness programs. The underlying requirements applicable to each type of health-contingent wellness program remain largely as proposed.

> **Wellness Programs in a Nutshell.** If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program is a participatory wellness program.* If the program requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward), the program is a health-contingent wellness program—either an activity-only wellness program or an outcome-based wellness program.†

* Treas. Reg. § 54.9802-1(f)(1)(ii); DOL Reg. § 2590.702(f)(1)(ii); HHS Reg. § 146.121(f)(1)(ii).

† Treas. Reg. § 54.9802-1(f)(1)(iii); DOL Reg. § 2590.702(f)(1)(iii); HHS Reg. § 146.121(f)(1)(iii).

a. Participatory Wellness Programs: Reward Not Based on Satisfying a Standard Related to a Health Factor

Wellness programs that do not condition eligibility for a reward based on an individual satisfying a standard that is related to a health factor (or if the program does not provide a reward) are

[20] Code § 9802(b)(2); ERISA § 702(b)(2); PHSA § 2705(b)(2).

[21] PHSA § 2705(j), as amended by PPACA, Pub. L. No. 111-148 (2010). PPACA added and amended various provisions of the PHSA, and then incorporated those provisions by reference into ERISA (ERISA § 715) and the Code (Code § 9815). PPACA, Pub. L. No. 111-148, §§ 1562(e) and (f) (2010).

[22] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 146 and 147, 78 Fed. Reg. 33158 (June 3, 2013).

© 2013 Thomson Reuters/EBIA

permissible if participation in the programs is available to all similarly situated individuals.[23] Examples of participatory wellness programs include—

- a program that reimburses employees for all or part of the cost for membership in a fitness center;
- a diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes;
- a program that encourages preventive care through the waiver of the co-payment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits;[24]
- a program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking-cessation program without regard to whether the employee quits smoking;
- a program that provides a reward to employees for attending a monthly, no-cost health education seminar; and
- a program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment.[25]

b. Health-Contingent Wellness Programs: Rewards Based on Satisfying a Standard Related to a Health Factor

Health-contingent wellness programs that condition eligibility for a reward upon an individual satisfying a standard that is related to a health factor are permissible only if they meet specific requirements. A health-contingent wellness program may be an activity-only wellness program or an outcome-based wellness program.

(i) Health-Contingent Wellness Programs: Activity-Only

An activity-only wellness program is a type of health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome. Examples include walking, diet, or exercise programs, which some individuals may be unable to participate in or complete (or have difficulty participating in or completing) due to a health factor, such as severe asthma, pregnancy, or a recent surgery.[26]

(ii) Health-Contingent Wellness Programs: Outcome-Based

An outcome-based wellness program is a type of health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. An outcome-based wellness program typically has two tiers. That is, for individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as an alternative to achieve the same reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program. That is, if a measurement, test, or screening is used as part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified medical conditions or risk factors (including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index, or high glucose level) and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range (or at risk) to take additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan,

---

[23] Treas. Reg. § 54.9802-1(f)(2); DOL Reg. § 2590.702(f)(2); HHS Reg. § 146.121(f)(2).

[24] Note that group health plans and health insurers are required to provide certain preventive health services on a first-dollar basis (PHSA § 2713(a), as added by PPACA, Pub. L. No. 111-148, § 1001(5) (2010); see Section XII for a discussion of this mandate); grandfathered health plans are exempt (see Section VI for a discussion of grandfathered health plans).

[25] Treas. Reg. § 54.9802-1(f)(1)(ii); DOL Reg. § 2590.702(f)(1)(ii); HHS Reg. § 146.121(f)(1)(ii). Note that the Genetic Information Nondiscrimination Act of 2008 (GINA) imposes additional restrictions on wellness programs that include health risk assessments. See Section XI of *HIPAA Portability, Privacy & Security* (Thomson Reuters/EBIA, 1997-present, updated quarterly).

[26] Treas. Reg. § 54.9802-1(f)(1)(iv); DOL Reg. § 2590.702(f)(1)(iv); HHS Reg. § 146.121(f)(1)(iv).

© 2013 Thomson Reuters/EBIA

complying with a walking or exercise program, or complying with a health care provider's plan of care) to obtain the same reward, the program is an outcome-based wellness program.[27]

(iii) Requirements for Health-Contingent Wellness Programs—Activity-Only and Outcome-Based

A health-contingent wellness program—either activity-only or outcome-based—must satisfy all of the following requirements:

- the program must give eligible individuals the opportunity to qualify for the reward under the program at least once per year;
- the reward for the program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed 30% of the total cost of employee-only coverage under the plan (50% for programs designed to prevent or reduce tobacco use);[28]
- the program must be reasonably designed to promote health or prevent disease;
- the full reward under the program must be available to all similarly situated individuals, and the program must allow reasonable alternative standards; and
- the plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated.[29]

Reasonable Alternative Standard Clarified. As noted above, one of the requirements that health-contingent wellness programs must meet is to provide a "reasonable alternative standard" for participants unable to meet the usual standard due to medical reasons. The plan or insurer may choose simply to waive the standard for those unable to comply for medical reasons, and it may establish alternatives on a case-by-case basis rather than in advance. Also, plans or insurers must provide or locate any educational program required to meet the standard, and, if the reasonable alternative involves a weight-loss program, must pay program membership fees but not the cost of food. The final regulations also clarify that for an alternative standard to be reasonable, the time commitment must be reasonable. For example, requiring attendance nightly at a one-hour class would be considered unreasonable.[30]

Medical Verification Not Always Required. Notably, while an activity-only program must offer a reasonable alternative standard to individuals for whom satisfying the program's standard is unreasonably difficult due to a medical condition (or is medically inadvisable), an outcome-based program must offer an alternative to any individual who does not meet the initial standard (i.e., without regard to whether the inability to meet the standard relates to a medical condition). In a related point, outcome-based programs cannot require medical verification that compliance with a standard is unreasonably difficult for an individual (whereas activity-only programs may require such verification).[31]

Notice of Reasonable Alternative Standard Required. As noted above, all plan materials describing a health-contingent wellness program must disclose the availability of a reasonable alternative standard. Revised sample language is provided. The final regulations clarify that communications that refer to the wellness program but do not provide details (such as the SBC) need not provide this disclosure.[32]

---

[27] Treas. Reg. § 54.9802-1(f)(1)(v); DOL Reg. § 2590.702(f)(1)(v); HHS Reg. § 146.121(f)(1)(v).

[28] However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. The cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

[29] Treas. Reg. § 54.9802-1(f)(3); DOL Reg. § 2590.702(f)(3); HHS Reg. § 146.121(f)(3) and Treas. Reg. § 54.9802-1(f)(4); DOL Reg. § 2590.702(f)(4); HHS Reg. § 146.121(f)(4).

[30] Treas. Reg. § 54.9802-1(f)(3)(iv); DOL Reg. § 2590.702(f)(3)(iv); HHS Reg. § 146.121(f)(3)(iv) and Treas. Reg. § 54.9802-1(f)(4)(iv); DOL Reg. § 2590.702(f)(4)(iv); HHS Reg. § 146.121(f)(4)(iv).

[31] Treas. Reg. § 54.9802-1(f)(4)(iv)(E); DOL Reg. § 2590.702(f)(4)(iv)(E); HHS Reg. § 146.121(f)(4)(iv)(E).

[32] Treas. Reg. § 54.9802-1(f)(3)(v); DOL Reg. § 2590.702(f)(3)(v); HHS Reg. § 146.121(f)(3)(v) and Treas. Reg. § 54.9802-1(f)(4)(v); DOL Reg. § 2590.702(f)(4)(v); HHS Reg. § 146.121(f)(4)(v).

© 2013 Thomson Reuters/EBIA

> **Anticipated Future Guidance.** The regulators have indicated that future subregulatory guidance may be issued, specifically with respect to verification of a participant's medical limitations by a medical professional, and rescission in connection with false statements about tobacco use.*

* Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 146 and 147, 78 Fed. Reg. 33158, 33167 (June 3, 2013).

For more information about health-contingent wellness programs, see Section XI of *HIPAA Portability, Privacy & Security* (Thomson Reuters/EBIA, 1997-present, updated quarterly).

3. Health Care Reform and Wellness Programs

There are several provisions in health care reform (discussed below) that place an emphasis on promoting and improving the effectiveness of workplace wellness programs. In addition, as discussed in more detail in Section XXXVI, the annual quality of care report required to be provided by group health plans and insurers to the Secretary of HHS (as well as enrollees under the plan or coverage) must address whether the plan or coverage implements wellness and health promotion activities.[33]

> **Wellness Programs and Preserving Grandfather Status.** Plans may continue to provide wellness incentives through, for instance, premium discounts or additional benefits to reward healthy behaviors. But penalties (e.g., increasing the surcharge on premiums for smokers) may implicate the types of changes that defeat grandfather status and may violate other nondiscrimination rules, so they should be examined carefully.* For more on grandfathered health plans, see Section VI.

* *See* FAQs About the Affordable Care Act Implementation Part II, Q/A-5, available at http://www.dol.gov/ebsa/faqs/faq-aca2.html (as visited June 3, 2013).

a. Increase in Health-Contingent Wellness Program Reward

As discussed above, the existing 2006 HIPAA regulations on nondiscrimination requirements for wellness programs were codified under health care reform with one significant change—effective for plan years beginning on or after January 1, 2014, a reward under a health-contingent wellness program may be up to 30% (increased from 20%) of the cost of coverage (and the DOL, HHS, and Treasury were given authority to increase this reward to 50% of the cost of coverage, if deemed appropriate).[34]

In final regulations issued in June 2013, the agencies increased the maximum permissible reward under a health-contingent wellness program from 20 to 30% of the cost of individual coverage under the group health plan, and up to 50% for programs designed to prevent or reduce tobacco use, effective for plan years beginning on or after January 1, 2014. The regulations do not set forth detailed rules governing apportionment of the reward under a health-contingent wellness program. Instead, plans and issuers have flexibility to determine apportionment of the reward among family members, as long as the method is reasonable. Additional subregulatory guidance may be provided if questions persist or if the agencies become aware of apportionment designs that seem unreasonable.[35]

---

[33] PHSA § 2717, as added by PPACA, Pub. L. No. 111-148, § 1001 (2010). HHS was required to issue regulations implementing this quality of care reporting requirement no later March 23, 2012 (i.e., two years after the enactment date of health care reform). Guidance under this provision remains outstanding. Grandfathered health plans are not required to comply with this requirement—for more information on grandfathered health plans, see Section VI.

[34] PHSA § 2705(j), as added by PPACA, Pub. L. No. 111-148, § 1201(4) (2010).

[35] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 146 and 147, 78 Fed. Reg. 33158, 33162 (June 3, 2013).

 © 2013 Thomson Reuters/EBIA

Complexities in Calculating the Maximum Permissible Reward. When calculating the maximum permissible reward, the full cost of coverage under the plan, including both the employer-paid and employee-paid portions, is counted.* While this may seem straightforward, the guidance does not expand on the meaning the phrase "cost of coverage." Thus, complying with the limit raises some thorny questions such as determining cost of coverage for a self-insured plan and challenges relating to midyear changes to cost of coverage. For a detailed discussion, see Section XI of *HIPAA Portability, Privacy & Security* (Thomson Reuters/EBIA, 1997-present, updated quarterly).

* Treas. Reg. § 54.9802-1(f)(3)(ii); DOL Reg. § 2590.702(f)(3)(ii); HHS Reg. § 146.121(f)(3)(ii).

In addition to compliance with nondiscrimination requirements, employers offering wellness programs must be mindful of the ADA. Wellness programs or discounts may violate the ADA if the discounts or other rewards are not available to individuals with disabilities. Also, depending on the structure, a wellness program could violate the ADA provisions limiting an employer's ability to make disability-related inquiries and to require medical examinations during employment.

Nondiscrimination Compliance Does Not Equal ADA Compliance. The 2006 HIPAA regulations confirm that compliance with the nondiscrimination rules and wellness program requirements does not ensure compliance with the ADA or other laws.* It is worth noting that health care reform's provisions do not address ADA compliance.

* Treas. Reg. § 54.9802-1(h); DOL Reg. § 2590.702(h); HHS Reg. § 146.121(h).

The ADA generally prohibits employment discrimination against disabled individuals and limits the circumstances in which an employer may require physical examinations or answers to medical inquiries[36] —both of which are features of many wellness programs. Neither the ADA itself nor subsequent EEOC guidance provides comprehensive analysis about how to determine whether medical examinations or inquiries are voluntary.

ADA Considerations When Using Wellness Rewards. Will health risk assessments that are part of an employer's wellness program be "voluntary" and thereby comply with the ADA if rewards are used to encourage employees to complete an assessment? One could argue that providing a reward for completing a health risk assessment would not make answering the medical inquiries on the assessment involuntary because the employee could still refuse to answer the inquiries (but forgo the reward). But the situation is muddied by the EEOC's failure to take any formal position on whether and to what extent financial incentives may be offered to participate in wellness programs that include disability-related inquiries or medical examinations.*

* EEOC Informal Discussion Letter (June 24, 2011), available at http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html (as visited June 3, 2013). In an earlier letter, the EEOC similarly stated that it was "continuing to examine what level, if any, of financial inducement to participate in a wellness program would be permissible under the ADA." EEOC Informal Discussion Letter (Mar. 6, 2009), available at http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html (as visited June 3, 2013). Note that informal discussion letters do not constitute the official opinion of the EEOC.

Absent some official guidance from the EEOC about what constitutes impermissible penalties or rewards, and what are voluntary programs under the ADA, there remains uncertainty as to whether the EEOC might take the position that a financial incentive or discount—especially one of more than nominal value—violates the ADA. Clear guidance from the EEOC in this important area would be welcome.

For more information about the ADA, see Section XX of *Group Health Plans: Federal Mandates Other Than COBRA & HIPAA* (Thomson Reuters/EBIA, 2002-present, updated quarterly).

[36] 42 U.S.C. § 12112(d); EEOC Reg. § 1630.14.

© 2013 Thomson Reuters/EBIA

b. Grants for Small Businesses to Provide Comprehensive Wellness Programs

PPACA creates a grant program to assist "eligible employers" to provide comprehensive workplace wellness programs.[37] Under this program, $200 million has been appropriated for the period 2011 through 2015.[38]

Who Is an "Eligible Employer" for Receipt of Small Business Grants? An eligible employer means an employer (including a nonprofit employer) that—

- employs less than 100 employees who work 25 hours or more per week; and
- did not provide a workplace wellness program as of March 23, 2010 (date of PPACA's enactment).*

In order to apply for a grant, eligible employers may submit an application to HHS that includes a proposal for a comprehensive workplace wellness program meeting the requisite criteria and requirements.†

* PPACA, Pub. L. No. 111-148, § 10408(b)(2) (2010).
† PPACA, Pub. L. No. 111-148, § 10408(d) (2010).

HHS is required to develop specific program criteria that are based on and consistent with evidence-based research and best practices.[39] A comprehensive workplace wellness program must be made available to all employees and include the following components:

- Health awareness initiatives (including health education, preventive screenings, and health risk assessments).
- Efforts to maximize employee engagement (including mechanisms to encourage employee participation).
- Initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials).
- Supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health).[40]

c. CDC Assistance With Employer-Based Wellness Programs

In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, PPACA authorizes the Centers for Disease Control and Prevention (CDC) to provide employers of all sizes with technical assistance, consultation, tools, and other resources (e.g., web portals, call centers) in evaluating employer-based wellness programs. This includes (1) methods to increase program participation; (2) developing standardized measures to assess the beneficial impact of the program on employees' health and health care expenditures; and (3) access evaluation tools to measure factors such as productivity, absenteeism, changes in employees' health status, and the medical costs incurred by employees.[41]

PPACA directs the Director of the CDC to conduct a national worksite health policies and program survey to assess employer-based health policies and programs. This was required by March 23, 2012 (i.e., two years after the enactment date of health care reform), and at regular intervals thereafter.[42] To this day, the initial survey remains outstanding. The CDC Director is also required to submit a report to Congress after the completion of each study with recommendations for the implementation of effective employer-based health policies and programs.[43]

[37] PPACA, Pub. L. No. 111-148, § 10408(a) (2010).
[38] PPACA, Pub. L. No. 111-148, § 10408(e) (2010).
[39] PPACA, Pub. L. No. 111-148, § 10408(c)(1) (2010).
[40] PPACA, Pub. L. No. 111-148, § 10408(c)(2) (2010).
[41] PHSA § 399MM, as amended by PPACA, Pub. L. No. 111-148, § 4303 (2010).
[42] PHSA § 399MM-1(a), as amended by PPACA, Pub. L. No. 111-148, § 4303 (2010).
[43] PHSA § 399MM-1(b), as amended by PPACA, Pub. L. No. 111-148, § 4303 (2010).

© 2013 Thomson Reuters/EBIA

d. Funds to Establish and Evaluate Workplace Health Promotion Programs

In June 2011, HHS made available $10 million to establish and evaluate comprehensive workplace health promotion programs.[44] The initiative will help an estimated 70 to 100 employers create and expand workplace health programs.[45] It is aimed at improving workplace environments so that they support healthy lifestyles and reduce risk factors for chronic diseases like heart disease, cancer, stroke, and diabetes.

The monies for this initiative were made available under the Prevention and Public Health Fund, which was established by health care reform, to provide for "expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs."[46] The $10 million allocated for workplace health promotion programs was to be awarded through a competitive contract to an organization with the expertise and capacity to work with employers to assist each participating employer with implementing the programs.[47] In September 2011, CDC announced that through a competitive process, two contractors have been chosen to support this initiative—one to work with employers to help them develop or expand their workplace health programs and the other to coordinate and administer a national evaluation of the program.[48]

---

[44] *See* HHS News Release: $10 Million in Affordable Care Act Funds to Help Create Workplace Health Programs (June 23, 2011), available at http://www.hhs.gov/news/press/2011pres/06/20110623a.html (as visited June 3, 2013).

[45] Comprehensive Health Programs to Address Physical Activity, Nutrition, and Tobacco Use in the Workplace (June 23, 2011), available at http://www.healthcare.gov/news/factsheets/wellness06232011a.html (as visited June 3, 2013).

[46] PPACA, Pub. L. No. 111-148, § 4002 (2010). The statute provides for funding starting at $500 million for fiscal year 2010, increasing each year thereafter until it reaches $2 billion for fiscal year 2015 and beyond—the funds are to be used to assist state and community efforts to prevent illness and promote health.

[47] For more information on the program structure, see Comprehensive Health Programs to Address Physical Activity, Nutrition, and Tobacco Use in the Workplace (June 23, 2011), available at http://www.healthcare.gov/news/factsheets/wellness06232011a.html (as visited June 3, 2013).

[48] Comprehensive Workplace Health Programs to Address Physical Activity, Nutrition, and Tobacco Use in the Workplace (Sept. 30, 2011), available at http://www.cdc.gov/workplacehealthpromotion/nhwp/index.html (as visited June 3, 2013).

[49] PHSA § 2706, as added by PPACA, Pub. L. No. 111-148, § 1201 (2010). See Section V for more on what is a group health plan for this purpose.

[50] PHSA § 2706, as added by PPACA, Pub. L. No. 111-148, § 1201 (2010).

[51] PPACA, Pub. L. No. 111-148, § 1255 (formerly PPACA § 1253) (2010).

[52] FAQs About the Affordable Care Act Implementation Part XV, Q/A-2, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html (as visited June 3, 2013).

© 2013 Thomson Reuters/EBIA