LOSE WEIGHT OR LOSE OUT: THE LEGALITY OF STATE MEDICAID PROGRAMS THAT MAKE OVERWEIGHT BENEFICIARIES' RECEIPT OF FUNDS CONTINGENT UPON HEALTHY LIFESTYLE CHOICES[†]

"Once your doctor's bill is no longer your own burden, your breakfast habits are no longer your own business."[1]

INTRODUCTION

On July 1, 2006, West Virginia implemented the United States' first and only penalty-based wellness pilot program for Medicaid beneficiaries.[2] Aimed at reducing Medicaid costs attributed to unhealthy behavior, this program limits the benefits of certain beneficiaries who do not conform to healthy lifestyles.[3] Beneficiaries are required to sign a "Medicaid Member Agreement" on behalf of themselves and their children.[4] This agreement requires beneficiaries' "[a]dherence to health improvement programs as directed by their health care provider," including taking all medications and not missing appointments.[5] While these beneficiaries will not lose all coverage if they do not comply with the prescribed health programs, their Medicaid coverage will be reduced to the basic benefit package, which provides greatly restricted benefits as compared to the enhanced benefit package they would receive for compliance.[6]

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1 Patrick McIlheran, *Your Breakfast, Our Business*, MILWAUKEE J. SENTINEL (Wis.), Dec. 14, 2007, at A19.

2 *See* PAT REDMOND ET AL., CTR. ON BUDGET & POL'Y PRIORITIES, CAN INCENTIVES FOR HEALTHY BEHAVIOR IMPROVE HEALTH AND HOLD DOWN MEDICAID COSTS? 4 (2007), http://www.cbpp.org/6-1-07health.pdf.

3 *See* Letter from Dennis G. Smith, Dir., Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., to Nancy V. Atkins, Comm'r, Bureau for Med. Servs., Dep't of Health & Human Resources (May 3, 2006), http://www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf [hereinafter Letter] (containing documents on West Virginia's wellness pilot program for Medicaid beneficiaries).

4 *See id.*

5 *Id.*

6 *See id.* (comparing benefits under the basic and enhanced packages).

One of West Virginia's primary motivations for this program is to reduce costs associated with overweight or obese Medicaid beneficiaries.[7] While the program's language does not specifically target obese beneficiaries,[8] the fact that the plan's history cites the reduction of waistlines as a principal goal,[9] coupled with the ability of the state to compel obese beneficiaries to lose weight under the existing program,[10] indicates that obese beneficiaries are a primary target of West Virginia's wellness program. This means that obese parents and children must either comply with weight-loss or exercise programs deemed appropriate by healthcare providers, or face the potential loss of enhanced medical coverage.[11]

While West Virginia's program is the first of its kind in the United States, it is consistent with the international trend with respect to obesity and healthcare: taxpayers do not want to pay for healthcare costs attributed to people's inability to control their eating habits.[12] For example, countries with publicly-funded universal healthcare, such as Britain and New Zealand, are beginning to express the belief that taxpayers should not finance poor eating choices.[13] To deal with obesity and other health concerns, Britain's Tory Party recently proposed a plan to deny National Health System treatments to citizens who continue to make unhealthy choices, stating, "It is inconsistent with the concept of the responsible citizen to imagine it is realistic for citizens, having paid their taxes, to expect that the state will underwrite the health implications of any lifestyle decision they choose to make."[14] New Zealand, another country with national healthcare, has gone one step further, denying residency

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[7] TRUST FOR AM.'S HEALTH, F AS IN FAT: HOW OBESITY POLICIES ARE FAILING IN AMERICA 37 (2007), *available at* http://healthyamericans.org/reports/obesity2007/Obesity2007Report.pdf. "It is estimated that [West Virginia] spent nearly $140 million on 'medical and pharmacy costs related to obesity' in 2002 alone. Given the high budgetary strain of obesity on the state, West Virginia is implementing initiatives within its Medicaid program to encourage enrollees to adopt healthier lifestyles." *Id.* (footnote omitted). Additionally, prior drafts of West Virginia's Medicaid Redesign Proposal include specific references to weight-loss services, mandating that beneficiaries maintain a Body Mass Index of twenty-five or less, and naming prevention and personal responsibility as "hallmarks" of the Redesign. W. VA. DEP'T OF HEALTH & HUMAN RESOURCES, WEST VIRGINIA COMPREHENSIVE MEDICAID REDESIGN PROPOSAL 1, 18 (2005), http://www.wvdhhr.org/bms/oAdministration/BMS_RedesignDraft_20051103.pdf.

[8] West Virginia's program applies to all people who live unhealthy lifestyles, such as smokers and excessive drinkers, and not just overweight or obese individuals. *See generally* Letter, *supra* note 3.

[9] *See supra* note 7 and accompanying text.

[10] *See infra* Part III.

[11] Letter, *supra* note 3.

[12] *See infra* notes 13–15 and accompanying text.

[13] Nicholas Cecil, *Lose Weight and Win 'Health Mile' Rewards, Pledge Tories*, EVENING STANDARD (London), Sept. 4, 2007, at A8.

[14] *Id.* (quotation marks omitted).

to immigrants who are "too fat" because of their potential burden on the healthcare system.[15] Since Medicaid is one of the only publicly-funded healthcare programs in America,[16] states looking to reform how Medicaid programs deal with obese beneficiaries are consistent with these international policies.

While extreme measures, such as New Zealand's policy, have not been implemented in the United States, drastic annual obesity-related Medicaid costs—ranging from $23 million in Wyoming to $3.5 billion in New York[17]—could push more states to implement harsher consequences for obese beneficiaries. Indeed, states have been experimenting with varying forms of Medicaid wellness programs for years to try to reduce obesity among beneficiaries.[18] However, until now, all state programs have been reward-based, offering incentives for maintaining healthy lifestyles; West Virginia marks the first state to punish Medicaid beneficiaries for failing to conform to mandated behavior.[19]

Such a shift in healthcare policy has substantial legal implications. Specifically, issues arise under two main principles: direct violations of the Federal Medicaid Act (FMA) and discrimination against obese beneficiaries by state Medicaid programs.[20] The question remains: can states implement penalty-based wellness programs that punish beneficiaries for being too fat? This Comment argues that as long as penalty-based wellness programs continue to provide coverage for populations mandated by the FMA and are careful not to specifically target the obese in the programs' language, so as to avoid discrimination, states are generally able to circumvent federal requirements and bend the purpose of Medicaid to make receipt of funds contingent upon lifestyle choices. However, this Comment concludes that, due to scientific and economic policy reasons, the implementation of such programs is not justified.

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[15] Amy Williams, *Skilled Worker Fails the Fat Test for Immigration*, NAT'L BUS. REV. (New Zealand), Nov. 16, 2007, http://www.nbr.co.nz/article/skilled-worker-fails-fat-test-immigration#Scene_1. This policy is consistent with New Zealand's tough immigrant-screening policies, which are intended to identify those that would place a "burden on the health system." Tony Wall, *Singing Star Quits NZ in Immigration Protest*, SUNDAY-STAR TIMES (Auckland, New Zealand), Oct. 30, 2005, at 7.

[16] The other is Medicare, a government-funded program that provides healthcare to the elderly and disabled. 42 U.S.C. §§ 1395–1395hhh (2006).

[17] Eric A. Finkelstein et al., *State-Level Estimates of Annual Medical Expenditures Attributable to Obesity*, 12 OBESITY RES. 18, 21 (2004).

[18] *See infra* Part I.B.

[19] REDMOND ET AL., *supra* note 2, at 4.

[20] *See infra* Parts II, III.

Part I of this Comment provides general background on obesity and wellness programs. Part II examines whether lifestyle-contingent programs violate the Medicaid statute, first examining access to courts for violations of the FMA, and then examining potential claims under the Act. Part III explores the interaction of these programs and nondiscrimination laws, first examining laws against disability discrimination, and then examining repercussions under the Equal Protection Clause of the Constitution. Finally, Part IV of this Comment suggests various nonlegal reasons why lifestyle-contingent wellness programs aimed at obese beneficiaries should not be implemented, even if they are legally sound.

I. OVERVIEW OF OBESITY AND WELLNESS PROGRAMS

To comprehend the legal implications of obesity-related penalty-based wellness programs, it is necessary to understand relevant background information regarding obesity and wellness programs. This Part briefly examines these preliminary topics in turn.

A. Obesity

"Obese" and "overweight" are terms used to indicate when individuals weigh more than is generally considered healthy for their heights.[21] Body mass index (BMI)[22] is commonly used to determine if an individual is overweight or obese:[23] an adult with a BMI between 25 and 29.9 is considered overweight, while an adult with a BMI of 30 or greater is considered obese.[24] Obesity is typically caused by energy imbalance (consuming more calories than expended), but the cause of energy imbalance is a complex interaction of behavior, environment, and genetics.[25] As a result of being obese, individuals

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[21] Ctrs. for Disease Control & Prevention, Overweight and Obesity: Defining Overweight and Obesity, http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm (last visited Aug. 30, 2008) [hereinafter CDC Definition].

[22] The BMI calculation is weight (lbs.), divided by height squared (in.^{2}), multiplied by a conversion factor of 703. Ctrs. for Disease Control & Prevention, About BMI for Adults (May 22, 2007), http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm.

[23] While BMI correlates with body fat, it is not a direct measure of body fat. Therefore, there are other methods of estimating body fat and BMI is only one of many indicators of potential health risks associated with being overweight or obese. CDC Definition, *supra* note 21.

[24] *Id.*

[25] NAT'L HEART, LUNG, & BLOOD INST., CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS: THE EVIDENCE REPORT 1 (1998); Ctrs. for

are at an increased risk for a variety of diseases and health problems, including hypertension, type-two diabetes, stroke, and some cancers.[26] There are multiple treatment options available for obese individuals, ranging from dietary therapy and physical activity to surgery.[27] However, due to the complex nature of what causes obesity,[28] the long-term effectiveness of treatment is tenuous.[29]

There has been a dramatic increase in the number of overweight and obese individuals in recent years[30]—a trend popularly coined "the obesity epidemic."[31] In response, politicians and researchers alike developed potential solutions, spurring considerable legislation as well as medical and social research.[32] This active response to the obesity epidemic is due to the "link between obesity and increased health risks, which translates into increased medical care and disability costs."[33] Expenditures associated with obesity have skyrocketed, totaling $75 billion annually for adults alone.[34] Taxpayers fund roughly half of this amount, with $38 billion of these expenditures financed by Medicaid and Medicare.[35] Businesses suffer as well, as healthcare costs

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Disease Control & Prevention, Overweight and Obesity: Contributing Factors, http://www.cdc.gov/nccdphp/dnpa/obesity/contributing_factors.htm (last visited Aug. 30, 2008).

[26] NAT'L HEART, LUNG, & BLOOD INST., *supra* note 25, at 12; Ctrs. for Disease Control & Prevention, Overweight and Obesity: Health Consequences (May 21, 2008), http://www.cdc.gov/nccdphp/dnpa/obesity/consequences.htm.

[27] NAT'L HEART, LUNG, & BLOOD INST., *supra* note 25, at 42.

[28] *Id.* at 11–12.

[29] *See* James D. Douketis et al., *Detection, Prevention and Treatment of Obesity*, 160 CANADIAN MED. ASS'N J. 513 (1999) (finding that there is insufficient evidence of long-term effectiveness of treatment options for obese individuals).

[30] Ctrs. for Disease Control & Prevention, Overweight and Obesity: U.S. Obesity Trends 1985–2007 (July 24, 2008), http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm.

[31] Scholars debate the existence and inflation of the obesity epidemic. *See generally* Paul Campos et al., *The Epidemiology of Overweight and Obesity: Public Health Crisis or Moral Panic?*, 35 INT'L J. EPIDEMIOLOGY 55 (2006) (arguing that the existence of an "obesity epidemic" has been seriously exaggerated).

[32] For example, there are at least five bills before the 110th Congress with the term "obesity" in the title, and far more that deal with reducing weight and improving health among Americans. GPO Access, Congressional Bills: 110th Congress Catalog, http://www.gpoaccess.gov/bills/index.html (follow the "All bills for the 110th Congress" hyperlink) (last visited June 30, 2008).

[33] NAT'L HEART, LUNG, & BLOOD INST., *supra* note 25, at 9 (citations omitted).

[34] Finkelstein et al., *supra* note 17, at 21.

[35] *Id.*

incurred by employers to cover obese employees—totaling $12 billion[36]—force businesses to face real financial dilemmas.[37]

B. Wellness Programs: Reward-Based and Penalty-Based

To reduce these obesity-related costs, healthcare providers are beginning to focus on prevention in the form of wellness programs.[38] Generally, these programs offer recipients incentives to make healthier lifestyle choices, which providers hope will translate into decreased weight, increased health, and ultimately decreased costs associated with obesity.[39]

Because American employers serve as key healthcare providers to employees, and are therefore spending large sums on healthcare, employers have embraced wellness programs to improve their bottom lines.[40] Such programs include worksite fitness plans, subsidized membership in local fitness clubs, educational and counseling programs, and financial incentives for employees who participate in weight-loss programs.[41] It appears that these wellness programs succeed in reducing employers' healthcare costs, as "[t]here are . . . whole literature reviews devoted to showing that, on average, worksite health promotion programs save employers money."[42]

Since Medicaid programs fund healthcare for nearly 46 million Americans,[43] states, following the lead of employers, have turned to wellness programs to help reduce the estimated $21 billion that obesity-related

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36 Milt Freudenheim, *Employers Plan Obesity Fight, Citing $12 Billion-a-Year Cost*, N.Y. TIMES, June 18, 2003, at C2.

37 Lisa Yoon, *Employers Look to Trim Fat*, CFO.COM, July 17, 2003, http://www.cfo.com/printable/article.cfm/3009696.

38 *See* Kathryn Hinton, Note, *Employer by Name, Insurer by Trade: Society's Obesity Epidemic and Its Effects on Employers' Healthcare Costs*, 12 CONN. INS. L.J. 137, 153–63 (2005) (discussing various employer-based wellness programs implemented to reduce obesity-related employee costs).

39 *Id.*

40 *Id.*

41 Thomas Krukowski & Timothy Costello, *Tipping the Scales: Weighing the Business Costs of Obesity*, WASH., D.C. EMP. L. LETTER, Dec. 2003, at 4.

42 ERIC A. FINKELSTEIN & LAURIE ZUCKERMAN, THE FATTENING OF AMERICA: HOW THE ECONOMY MAKES US FAT, IF IT MATTERS, AND WHAT TO DO ABOUT IT 189 (2008); *see* U.S. DEP'T OF HEALTH & HUMAN SERVS., PREVENTION MAKES COMMON "CENTS" 23 (2003), http://aspe.hhs.gov/health/prevention (describing a study by the Department of Health and Human Services, which reports a significant return on investment for nine major employers' wellness programs—including Johnson & Johnson and General Motors—ranging from $1.49 to $4.91 in benefits per dollar spent).

43 *President's Fiscal Year 2006 Budget for the U.S. Department of Health and Human Services: Hearing Before the H. Comm. on Ways & Means*, 109th Cong. 10 (2005) [hereinafter *Hearings*] (statement of Michael Leavitt, Sec'y, U.S. Dep't of Health & Human Servs.).

Medicaid services are costing states annually.[44] Medicaid wellness programs are primarily reward-based, using various forms of discounts or monetary reimbursements to incentivize use of preventive services and healthy lifestyle choices.[45] For example, Florida's Enhanced Benefits program provides beneficiaries who participate in weight-loss programs with $15 to $25 credits that can be redeemed for health-related products at drug stores.[46] California's Medi-Cal program offers gift certificates or movie tickets to parents who bring in their children for preventive visits, and to adolescents who make such visits themselves.[47]

It is unclear whether these Medicaid wellness programs will achieve the same success as those implemented by employers.[48] Available empirical data is scarce,[49] and while the data generally indicates that rewards for preventive behaviors can be effective, studies fail to focus on Medicaid beneficiaries specifically, or to distinguish compounding factors.[50] In 2004, there was a comprehensive review of the effect of financial incentives on preventive behavior.[51] Researchers found that while the incentives appeared to work for low-income persons in the short term, there was little evidence that they would work in the long term, though it was unclear why.[52] These findings, combined with the increased administrative costs of implementing these programs, have some researchers warning that "[r]ewarding beneficiaries for behavior is unlikely to have significant effects either in reducing Medicaid program costs or in improving the overall health status of the Medicaid population."[53]

This uncertain success of Medicaid reward-based wellness programs, as well as high obesity-related Medicaid costs, led policymakers in West Virginia

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44 Finkelstein et al., *supra* note 17, at 21.

45 *See* REDMOND ET AL., *supra* note 2, at 2–4 (noting that there is only one state wellness program thus far that is not reward-based).

46 *Id.* at 4.

47 *Id.* at 2.

48 *Id.*

49 *See id.* ("Few rigorous studies have been conducted on the impact of financial rewards on health-related behavior . . . . None . . . focus specifically on incentives provided to Medicaid beneficiaries.").

50 Such compounding factors include offering rewards to providers or removing financial barriers. REDMOND ET AL., *supra* note 2, at 2, 6.

51 *See* Robert L. Kane et al., *A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior*, 27 AM. J. PREVENTIVE MED. 329, 347 (2004). Vulnerable, low-socioeconomic-status populations were the most frequently studied, and seven of the studies specifically addressed obesity and weight loss. *Id.*

52 *Id.* Potential reasons for this result are discussed *infra* Part IV.A.

53 REDMOND ET AL., *supra* note 2, at 6. For a similar view, see John Holahan & Alan Weil, *Toward Real Medicaid Reform*, 26 HEALTH AFF. 254 (2007).

to explore a new alternative: wellness programs that limit an individual's receipt of Medicaid funds when the individual engages in unhealthy behaviors.[54] Unlike reward-based wellness programs, this option is penalty-based—punishing those who do not comply with prescribed healthy lifestyles, by reducing their Medicaid benefits.[55] While penalty-based programs have not been popular in the past,[56] rising costs have created a public cry for "personal responsibility," and for punishing those who force others to pay for their unhealthy "choices."[57]

II. PENALTY-BASED WELLNESS PROGRAMS AND THE MEDICAID STATUTE

A primary legal concern raised by state penalty-based wellness programs is whether they violate the requirements of the FMA. Medicaid is a means-based healthcare program, created in 1965 under Title XIX of the Social Security Act.[58] Federal and state laws dictate eligibility for the program.[59] Federal law requires coverage for mandatory groups, determined by income and resources below a certain threshold, and inclusion in one of the required eligibility groups.[60] States can opt to cover additional groups,[61] but in electing to do so must meet certain federal coverage requirements.[62] Additionally, federal guidelines advance mandatory and optional Medicaid services.[63]

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54 REDMOND ET AL., *supra* note 2, at 4.

55 *Id.*

56 *See id.*

57 *See* Karen Tumulty, *The Politics of Fat*, TIME, Mar. 27, 2006, at 43 ("[T]here are plenty of people who argue that the blame—and the answer—must lie squarely with fat people themselves . . . . [T]here is one thing on which all sides can agree: nothing will work until Americans are persuaded to change the choices they are making for themselves . . . ."). On the federal level, the Commonsense Consumption Act of 2005 would have allowed the government to determine "appropriate laws, rules, and regulations to address the problems of weight gain, obesity, and health conditions associated with weight gain or obesity." S. 908, 109th Cong. On the state level, in 2008, Mississippi representatives introduced a bill that would have banned restaurants from serving obese patrons. H.R. 282, 2008 Leg., Reg. Sess. (Miss. 2008). While these bills never became law, they are strongly indicative of a political and social trend toward personal responsibility.

58 Ctrs. for Medicare & Medicaid Servs., Medicaid Program—General Information: Technical Summary (Dec. 14, 2005), http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp.

59 *See infra* notes 60–63 and accompanying text.

60 These mandatory groups include children under age six below 133% of the federal poverty level (FPL), pregnant women under 133% of the FPL, certain parents, and elderly and disabled Supplemental Security Income (SSI) beneficiaries below 74% of the FPL. 42 U.S.C. § 1396a(a)(10)(A)(i) (2006).

61 These optional groups include low-income children above 100% of the FPL who are not mandatory by age, pregnant women above 133% of the FPL, the disabled and elderly below 100% of the FPL but above the SSI level, and certain working disabled. *Id.* § 1396a(a)(10)(A)(ii).

62 *Id.*

63 *Id.* § 1396d(a); *see* Ctrs. for Medicare & Medicaid Servs., *supra* note 58.

While the federal government matches funds expended by the states that opt in,[64] states are responsible for management of Medicaid programs.[65] Therefore, states can conceivably create penalty-based wellness programs aimed at reducing the cost of obese beneficiaries via these management responsibilities. However, these programs must comply with federal mandates regarding both services provided and persons covered.[66] This Part first examines the ability of beneficiaries to access federal courts in response to state violations of the FMA. Second, assuming beneficiaries can access the courts, this Part explores the likelihood that they will succeed in litigating claims that penalty-based wellness programs violate the FMA.

A. *Access to the Courts for Violations of the Federal Medicaid Act*

Although "Medicaid has come to be accepted as a federal entitlement,"[67] obese beneficiaries may not be able to access the courts to defend the benefits to which they are entitled. This is because the Medicaid statute fails to explicitly provide a private right of action for beneficiaries to enforce their rights in court.[68] Conversely, the Medicare statute[69] specifically provides an individual right of action for enforcement.[70] However, although the FMA does not provide an explicit private right of action, courts have long recognized that beneficiaries have such a right under 42 U.S.C. § 1983.[71] Section 1983 is part of the Civil Rights Act of 1871 and generally allows individuals who have been deprived of rights, privileges, or immunities secured by the Constitution and federal laws to sue state actors.[72]

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64 Currently all fifty states opt to cover optional groups. KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID'S OPTIONAL POPULATIONS: COVERAGE AND BENEFITS 1 (2005), http://www.kff.org/medicaid/upload/Medicaid-s-Optional-Populations-Coverage-and-Benefits-Issue-Brief.pdf.

65 *See* 42 U.S.C. § 1396.

66 *See* text accompanying notes 61–63.

67 Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, 22 HEALTH AFF. 145, 147 (2003); *see also* Schweiker v. Gray Panthers, 453 U.S. 34, 36–37 (1981) ("An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives."); Jane Perkins, *Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7, 7 (2002) ("Since its enactment . . . in 1965, Medicaid has been an entitlement program for beneficiaries and states.").

68 *See* Jost, *supra* note 67, at 146.

69 42 U.S.C. §§ 1395–1395hhh (2006). Medicare is a government-funded program that provides healthcare to the elderly and disabled.

70 *Id.* § 1395ff(b)(1)(A).

71 Perkins, *supra* note 67, at 32; *see also* Maine v. Thiboutot, 448 U.S. 1, 4 (1980) (holding that § 1983 applies to claims based solely on violations of federal statutes and, therefore, extends to claims regarding deprivation of welfare benefits under the Social Security Act). For Medicaid beneficiaries, suits will be brought under 42 U.S.C. § 1396a(a), which details what a state plan for medical assistance must provide.

72 42 U.S.C. § 1983 (2006).

While it is possible for obese beneficiaries to bring suits under § 1983 to challenge the denial of Medicaid services under penalty-based wellness programs, such as West Virginia's, there are barriers to bringing such suits. Initially, a plaintiff seeking § 1983 redress "must assert the violation of a federal *right*, not merely a violation of federal *law*."[73] The United States Supreme Court set forth a three-factor test, known as the *Blessing* test, to determine whether the right in question can be enforced under § 1983: First, the plaintiff must be an intended beneficiary of the statute. Second, the plaintiff's asserted rights under the statute must not be "so vague and amorphous as to be beyond the competence of the judiciary to enforce." Third, the statute must impose a binding obligation on the state.[74]

Further, in 2002 the Supreme Court added a wrinkle to the *Blessing* test, making it more difficult for Medicaid beneficiaries to access the courts. In *Gonzaga University v. Doe*,[75] the Supreme Court clarified the first factor of the *Blessing* test, holding that nothing short of "unambiguously conferred right[s]," as opposed to vague benefits or interests, are enforceable under § 1983.[76] Therefore, for a court to determine that Congress intended to confer such individually enforceable rights upon a class of beneficiaries, the relevant statute must contain "rights-creating" language demonstrating this congressional intent.[77]

The likelihood of Medicaid beneficiaries successfully passing the *Blessing* test is uncertain. Regarding the first and most formidable test, courts examine each subsection of 42 U.S.C. § 1396a, which details the requirements of state Medicaid plans, to determine if the particular language is "rights-creating."[78] Therefore, beneficiaries face two issues: under which provision of § 1396a to bring their claims, and how the jurisdiction where they bring suit has treated that particular section. Since *Gonzaga*, lower courts are split over which of the seventy subsections of § 1396a grant enforceable rights under § 1983.[79] For

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[73] Blessing v. Freestone, 520 U.S. 329, 340 (1997).

[74] *Id.* at 329–30.

[75] 536 U.S. 273 (2002).

[76] *Id.* at 283.

[77] *Id*. at 287; *see also* Westside Mothers v. Olszewski, 454 F.3d 532, 542–43 (6th Cir. 2006).

[78] *See Gonzaga*, 536 U.S. at 287; *Westside Mothers*, 454 F.3d at 542–43.

[79] See Brian J. Dunne, Comment, *Enforcement of the Medicaid Act Under* 42 USC § 1983 *After* Gonzaga University v. Doe*: The "Dispassionate Lens" Examined*, 74 U. CHI. L. REV. 991, 1003–11 (2007) (discussing the circuit splits after *Gonzaga* regarding whether Medicaid beneficiaries can bring suit under certain sections of the FMA).

example, in *Watson v. Weeks*,[80] the Ninth Circuit Court of Appeals found that § 1396a(a)(17)[81] did not grant enforceable rights, effectively ensuring that "millions of Medicaid beneficiaries in [the] nation's largest judicial circuit are no longer guaranteed treatment not specifically enumerated in § 1396d(a)(1)–(5)[82] no matter how many physicians certify this treatment as medically necessary."[83] In contrast, the Eighth Circuit held in *Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services* that § 1396a(a)(30)(A) of the FMA was intended to benefit certain Medicaid recipients and providers, conferring enforceable rights on both groups.[84] Therefore, the success of beneficiaries bringing § 1983 suits for violations of the FMA by a penalty-based wellness program depends largely on where they bring the suits, creating a formidable barrier to access for many Medicaid beneficiaries.[85]

B. Statutory Requirements of the Federal Medicaid Act

Assuming beneficiaries are able to access the courts under § 1983, it is highly unlikely that they will succeed in arguing that states with penalty-based wellness programs aimed at obese beneficiaries violate the FMA. This is due to the ability of states to circumvent federal law via federal programs designed to give states flexibility in designing their Medicaid programs.[86]

While the federal government matches funds expended by states that opt in,[87] state responsibility for the management of Medicaid programs allows them very broad discretion over the programs and causes great variation from state to state.[88] Since its creation, Medicaid has been expanded beyond its original intent, resulting in rapid growth in both the numbers of people covered

[80] 436 F.3d 1152 (9th Cir. 2006).

[81] This section requires that state Medicaid programs provide comparable reasonable standards for determining eligibility. 42 U.S.C. § 1396a(a)(17).

[82] This means that beneficiaries are not entitled to the twenty-two other services listed under § 1396d(a), including dental services, § 1396d(a)(10), physical therapy and related services, § 1396d(a)(11), prescribed drugs, § 1396d(a)(12), and respiratory care services, § 1396d(a)(20).

[83] Dunne, *supra* note 79, at 1011 (emphasis omitted).

[84] 443 F.3d 1005, 1015–16 (8th Cir. 2006), *vacated in part sub nom.* Selig v. Pediatric Specialty Care, Inc., 127 S. Ct. 3000 (2007) (mem.).

[85] *See id.* at 1003–13 (detailing the circuit split in the lower courts in response to *Gonzaga*).

[86] *See infra* Part III.B.1–2.

[87] *See supra* note 64.

[88] Ctrs. for Medicare & Medicaid Servs., *supra* note 58.

and annual expenditures.[89] The costs of Medicaid have more than doubled in the past decade[90] and the program is expected to provide care for 46 million Americans at a cost of $358 billion in 2008.[91] States are feeling the financial strain as well, having spent more on Medicaid than education for the first time ever in 2004.[92]

Due to this astronomical spending, which is expected to reach $5 trillion by 2015,[93] federal and state governments constantly look to control the exponential growth of Medicaid costs.[94] In the past, the rigid federal Medicaid requirements made it difficult for states to reduce costs without violating the FMA.[95] However, states now have two options to circumvent or even change these federal requirements—the Deficit Reduction Act of 2005 and § 1115 waivers—either of which allow states to implement penalty-based wellness programs aimed at reducing the waistlines of beneficiaries.

1. The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006,[96] aims to reduce federal spending by permitting federal entitlement reductions.[97] In an effort to reduce Medicaid spending by $26.1 billion by 2015, the DRA permits policy changes in coverage and access to benefits for Medicaid recipients upon approval by the Secretary of the Department of

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89 *Id.*; Nina Owcharenko, *A Road Map for Medicaid Reform*, BACKGROUNDER NO. 1836, June 21, 2005, *available at* http://www.heritage.org/Research/HealthCare/upload/79812_1.pdf.

90 Dirk Kempthorne, Address to the Federal Medicaid Commission 1 (Jan. 26, 2006), http://aspe.hhs.gov/medicaid/jan/kempthorne.pdf.

91 *See* OFF. OF MGMT. & BUDGET, DEP'T OF HEALTH & HUMAN SERVS., BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2008, http://www.whitehouse.gov/omb/budget/fy2008/hhs.html (calculating $358 billion from the fact that $204 billion is 57% of annual Medicaid expenditures).

92 Kempthorne, *supra* note 90, at 1.

93 *Id.*

94 *See, e.g.*, *At a Glance*, USA TODAY, Feb. 5, 2008, at 5A (discussing a 2009 budget proposal that includes both presidential and congressional plans to trim Medicaid spending over the next five years); Stephanie Simon, *States Rein in Health Costs*, L.A. TIMES, Apr. 24, 2005, at A1 (discussing the 2006 budget, which cut Medicaid funding by over $1 billion because of enormous costs).

95 Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 546 (1995) ("[S]tates' . . . concern with the growth of Medicaid costs . . . has involved obtaining exemptions from the complex requirements of the Social Security titles . . . .").

96 The Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 42 U.S.C.).

97 KAISER COMM'N ON MEDICAID & THE UNINSURED, DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR MEDICAID 1 (2006), http://www.kff.org/medicaid/upload/7465.pdf.

Health and Human Services (DHHS).[98] These changes include allowing states to adjust beneficiaries' premiums and implement cost-sharing practices, reducing pharmacy reimbursements for prescription drugs, and implementing reduced benefits in the form of "benchmark" coverage plans.[99] These benchmark plans allow the reduction in coverage for nonmandatory groups to the bare minimum, so long as states provide children with "wrap-around," or comprehensive back-up, coverage for mandatory services under Medicaid's Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program.[100]

States wishing to implement penalty-based wellness programs that include restrictions for obese beneficiaries could easily do so under the DRA State Flexibility Benefits Packages. West Virginia chose this option when implementing its pilot program,[101] which provides alternative benefit packages to certain parents and children enrolled in Medicaid.[102] Beneficiaries are entitled to receive a basic benefit package, which offers fewer benefits than West Virginia's previous Medicaid program.[103] However, these parents and children can receive an enhanced benefit package, which offers coverage for more services than the scaled-back basic package.[104] But to receive these enhanced benefits, parents must sign (for themselves and on behalf of their children) a "Medicaid Member Agreement," which states that the members will comply with the health programs as directed by their healthcare providers, or their Medicaid coverage will be reduced to the basic benefit package.[105]

West Virginia's plan complies with the DRA requirements. First, it does not apply to mandatory Medicaid populations.[106] Second, the program includes EPSDT in the services provided under the basic benefit package for children, so wrap-around coverage is unnecessary.[107] Finally—and most

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[98] *Id.*

[99] *Id.* at 1–5.

[100] *See* 42 U.S.C. § 1396u-7(a)(1)(A)(ii) (2006).

[101] Letter, *supra* note 3, at 1.

[102] JUDITH SOLOMON, CTR. ON BUDGET & POLICY PRIORITIES, WEST VIRGINIA'S MEDICAID CHANGES UNLIKELY TO REDUCE STATE COSTS OR IMPROVE BENEFICIARIES' HEALTH 2 (2006), http://www.cbpp.org/5-31-06health.pdf.

[103] *Id.* at 2–3.

[104] For a detailed comparison of the services offered under each benefit package, see Letter, *supra* note 3, attach. 2, at 2–6.

[105] *Id.* attach. 2, at 2–3.

[106] *See id.* at 1.

[107] *See id.* attach. 2, at 2. While EPSDT is included in the children's basic benefit package, the plan "excludes certain services that EPSDT covers, and it limits other such services." SOLOMON, *supra* note 102, at 2 (emphasis omitted).

importantly—West Virginia obtained approval for their program from the Secretary of DHHS,[108] effectively endorsing any of the program's variations from FMA requirements.

It appears that as long as programs comply with the bare minimum of federal mandates, and secure the approval of DHHS, states are free to construct Medicaid programs that bend the requirements of federal law. Not only are these minimum mandates easily met, but obtaining Secretary approval is likely not difficult given the strong current political and social desire to reduce soaring Medicaid costs.[109] Therefore, states using DRA benefit packages are both legally and politically supported in their goal of reducing spending at the expense of FMA requirements, facilitating the ability of states to create a variety of penalty-based wellness programs. However, while the DRA is likely to reduce federal spending on Medicaid, the impact on beneficiaries is potentially devastating; policy changes are apt to cause less access to services, reduction in quality of services, and reduction in available benefits, while simultaneously increasing the costs of obtaining them.[110]

2. Section 1115 Waivers

Another avenue available for states seeking to avoid strict federal Medicaid requirements is § 1115 waivers. Section 1115 waivers are granted by the DHHS for state "experiential, pilot, or demonstration projects" that "promot[e] the objectives of Medicaid."[111] These waivers were designed to encourage experimentation with Medicaid programs to allow states to expand coverage as desired,[112] and initially states pursued this goal by using waivers only to enhance Medicaid benefits or extend coverage to populations not already covered under Medicaid.[113] However, consistent with the DRA, this goal has

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[108] *See* Letter, *supra* note 3, at 3. In creating a benchmark benefit package, states can choose to model their programs after HMO plans, other insurance plans, state employee programs, or have the Secretary of DHHS approve their plans. 42 U.S.C. § 1396u-7(b)(1) (2006).

[109] *See supra* text accompanying notes 89–96.

[110] *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, *supra* note 97 (discussing the impact of budget cuts on Medicaid); *see also infra* Part IV (suggesting policy reasons why lifestyle-contingent wellness programs aimed at obese beneficiaries should not be implemented).

[111] 42 U.S.C. § 1315 (2006).

[112] *Id.*; *see* Joshua Tenzer, Note, *Reaching the Final Frontiers in Medicaid Managed Care*, 62 N.Y.U. ANN. SURV. AM. L. 329, 348 (2006).

[113] *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, SECTION 1115 MEDICAID AND SCHIP WAIVERS: POLICY IMPLICATIONS OF RECENT ACTIVITY 1 (2003), http://www.kff.org/medicaid/upload/Section-1115-Medicaid-and-SCHIP-Waivers-Policy-Implications-of-Recent-Activities-Policy-Brief.pdf ("[E]arlier

been substituted with the goal of reducing costs.[114] States have begun to use § 1115 waivers to reduce coverage and benefits for beneficiaries,[115] allowing states to circumvent federal requirements for Medicaid programs.[116]

There are several factors contributing to this shift in policy. Most conspicuous are the rise in healthcare costs and pressing budget constraints,[117] coupled with the ever-advancing negative view of Medicaid as an entitlement.[118] Most significant, however, are the political, legislative, and judicial backing of such waivers, beginning with the Clinton Administration. In 1993, President Clinton began directing DHHS to "streamline the Medicaid waiver process."[119] This action was followed by a wealth of activity from DHHS to make it easier and faster for states to get § 1115 waivers approved, including "approving waivers for longer periods . . . limit[ing] the administrative constraints on the states and reduc[ing] the processing time for waiver requests."[120] This streamlining process was later codified under the Balanced Budget Act of 1997.[121]

In 2001, the Bush Administration continued this trend with the Health Insurance Flexibility and Accountability Initiative (HIFA).[122] This initiative is a § 1115 waiver that further increases flexibility over state Medicaid programs

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waivers . . . often utilized savings derived from managed care and resulted in large expansions. Recent waivers are not necessarily focused primarily on expanding coverage . . . .").

[114] *See* Rosenberg & Zaring, *supra* note 95, at 550 ("The new flexibility in Section 1115 waiver administration has ushered in an era in which waivers are granted not so much to improve the delivery of program benefits but rather to reduce program costs.").

[115] SAMANTHA ARTIGA & CINDY MANN, KAISER COMM'N ON MEDICAID & THE UNINSURED, NEW DIRECTIONS FOR MEDICAID SECTION 1115 WAIVERS: POLICY IMPLICATIONS OF RECENT WAIVER ACTIVITY 5 (2005), http://www.kff.org/medicaid/upload/New-Directions-for-Medicaid-Section-1115-Waivers-Policy-Implications-of-Recent-Waiver-Activity-Policy-Brief.pdf.

[116] *Id.* at 1 ("Section 1115 waivers give states federal approval to alter the way they provide coverage and/or deliver services . . . outside of the federal standards and options and still receive federal matching funds. That is, they allow states to use federal Medicaid funds in ways not otherwise allowed under federal law.").

[117] *See* Rosenberg & Zaring, *supra* note 95, at 552. "[T]he astronomical rise in Medicaid costs has caused states to seek out Section 1115 waivers to enable them to make the most efficient use of their health care dollars." *Id.* (citation omitted). *See also supra* text accompanying notes 89–96.

[118] *See, e.g.*, Perkins, *supra* note 67, at 8 ("Medicaid may become a target of legislative and judicial decisionmakers . . . who see the Medicaid entitlement as antithetical to their concepts of states' rights and a reduced federal role.").

[119] Rosenberg & Zaring, *supra* note 95, at 549.

[120] *Id.* at 550; *see also* Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures, 59 Fed. Reg. 49,249 (Sept. 27, 1994).

[121] Pub. L. No. 105-33, 111 Stat. 251 (codified as amended in scattered sections of 42 U.S.C.).

[122] *See* EDWIN PARK & LEIGHTON KU, CTR. ON BUDGET & POLICY PRIORITIES, ADMINISTRATION MEDICAID AND SCHIP WAIVER POLICY ENCOURAGES STATES TO SCALE BACK BENEFITS SIGNIFICANTLY AND INCREASE COST-SHARING FOR LOW-INCOME BENEFICIARIES 1 (2001), http://www.cbpp.org/8-15-01health.pdf.

in terms of cost-sharing, benefits offered, and enrollment caps, all while offering a "simple application process and an expedited review."[123]

Although the Secretary of DHHS has some restrictions on his or her ability to grant waivers,[124] "[c]ourts have approved broad federal authority to waive Medicaid requirements."[125] This has led to over seventeen waivers being approved and implemented between January 2001 and March 2005, many of which focused on reducing coverage by increasing cost-sharing, capping enrollment, and reducing benefits for Medicaid recipients without actually implementing any expansion programs.[126]

States that wish to create penalty-based wellness programs to incentivize obese beneficiaries to lose weight could easily do so utilizing § 1115 waivers. A state would have to ensure budget neutrality, demonstrating that their proposed program would not result in more spending than would result without the waiver. Additionally, the state would have to include some form of coverage expansion and, much like West Virginia's program, ensure that the proposed plan does not reduce the services provided to mandatory Medicaid populations.[127] The ability to meet these limited requirements for receiving § 1115 waivers, combined with the strong political backing of such programs, creates a fertile atmosphere for the creation of a variety of questionable programs that would not violate the requirements of the FMA.

For obese individuals attempting to protect their rights to receive Medicaid funds, the belief that they will succeed in arguing that penalty-based programs violate the Medicaid statute can be described as questionable.[128] The absence of an express private right of action in the federal statute creates a strong initial barrier to beneficiaries seeking redress. Combined with the availability of

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[123] Laura Tobler, Nat'l Conf. of State Legislatures, Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative (Mar. 2003), http://204.131.235.67/programs/health/hifa.htm.

[124] For example, HIFA demonstrations must be budget neutral, which means that they cannot "result in a higher level of federal spending than would have occurred without the waiver." State Coverage Initiatives, Matrix Glossary, Medicaid, SCHIP, and Federal Authority, http://statecoverage.net/matrix/waivers.htm (last visited Sept. 19, 2008). Additionally, HIFA waivers cannot reduce the services provided to mandatory Medicaid populations, and must include some form of coverage expansion. *Id.*

[125] Tenzer, *supra* note 112, at 348.

[126] *See* ARTIGA & MANN, *supra* note 115, at 5–19 (describing § 1115 waivers that have been granted). For a complete list of the waivers implemented for individual states, see Ctrs. for Medicare & Medicaid Servs., Medicaid Waivers and Demonstrations List, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp (last visited Sept. 28, 2008).

[127] *See supra* note 106 and accompanying text.

[128] *See* Jost, *supra* note 67, at 145.

§ 1115 waivers for states to circumvent federal Medicaid requirements, and the implementation of policy changes under the DRA, all beneficiaries face an uphill battle, particularly obese individuals who may carry with them the stigma of contempt.[129] While neither HIFA waivers nor DRA benchmark programs can reduce benefits for mandatory Medicaid populations,[130] programs can easily be constructed around this requirement, as seen by West Virginia's program.[131] This leaves 15 million Americans, who are optional Medicaid beneficiaries, defenseless against implementation of penalty-based wellness programs.[132]

III. PENALTY-BASED WELLNESS PROGRAMS AND DISCRIMINATION

Another serious legal concern raised by penalty-based wellness programs is whether they discriminate against obese beneficiaries. While there are no federal statutes prohibiting discrimination based on appearance,[133] there are federal laws prohibiting discrimination based on health factors and disabilities, as well as constitutional protections against states denying citizens equal protection under the law.[134] However, none of these laws provide sufficient legal protection to obese beneficiaries against penalty-based Medicaid programs.

A. Health-Based Discrimination

This section examines the federal statutes under which individuals can bring disability discrimination suits and the likelihood of success for obese individuals under these laws. First, this section discusses the new regulations under the Health Insurance Portability and Accountability Act (HIPAA). Second, this section focuses on Title II of the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.

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129 *See supra* notes 14, 15, 57 and accompanying text.

130 State Coverage Initiatives, *supra* note 124; *see also* 42 U.S.C. § 1396u-7 (2006).

131 *See supra* notes 106–08 and accompanying text.

132 *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: AN OVERVIEW OF SPENDING ON "MANDATORY" VS. "OPTIONAL" POPULATIONS AND SERVICES 1 (2005), http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf (calculated by determining 29% of the 52 million individuals who receive Medicaid benefits).

133 Jennifer Shoup, Note, *Title I: Protecting the Obese Worker?*, 29 IND. L. REV. 207, 214 (1995).

134 These include HIPAA, the ADA, § 504 of the Rehabilitation Act, and the Equal Protection Clause of the U.S. Constitution, discussed *infra* Part III.A–C.

1. HIPAA: Discrimination Based on Health Factors

Congress enacted HIPAA in 1996 to, among other things, "improve portability and continuity of health insurance coverage."[135] HIPAA amended the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act to prohibit discrimination against individual participants or beneficiaries in group health plans based on their health factors.[136] On December 13, 2006, the Internal Revenue Service, the Department of Labor, and the DHHS published final rules regarding the HIPAA nondiscrimination provisions and their applicability to wellness programs.[137] These final rules apply to Medicaid because Medicaid is a covered entity under HIPAA.[138]

The HIPAA regulations generally prohibit discrimination against an individual in terms of eligibility and coverage based on health factors, including health status, medical conditions, and medical history.[139] However, there are two exceptions. The first is that a group health plan may impose limits on benefits if the limits apply to all similarly situated individuals.[140] Therefore, a plan can "limit or exclude benefits in relation to a specific disease or condition" as long as the limits are not directed at an individual, but are uniformly applied to all those similarly situated.[141] This means that as long as penalty-based wellness programs do not target an obese or overweight individual, but instead apply to all individuals with that "condition"—being overweight—these programs are not considered to discriminate based on a health condition.

The second exception to HIPAA's discrimination rules is for wellness programs.[142] The final rules governing nondiscrimination under HIPAA state the following: "[These rules] do not prevent a plan or issuer from establishing premium discounts or rebates or modifying otherwise applicable co-payments or deductibles *in return for adherence to programs of health promotion and*

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135 Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 42 U.S.C.).

136 *See* Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014 (Dec. 13, 2006) (to be codified at 45 C.F.R. pt. 146).

137 *Id.* The regulations became effective for plan years beginning on or after July 1, 2007. *Id.*

138 42 U.S.C. § 1320d(5)(F) (2006).

139 26 C.F.R. § 54.9802-1(a) (2007).

140 *Id.* § 54.9802-1(b)(2)(i)(A)–(B).

141 Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. at 75,031.

142 *Id.* at 75,017.

disease prevention."[143] Therefore, if a group health plan uses health factors to discriminate against individuals based on participation in a program of health promotion or disease prevention—a wellness program—there is no violation of HIPAA.[144] For example, West Virginia's program reduces benefits for certain beneficiaries who do not comply with health promotion programs as required by their healthcare providers or physicians.[145] The state *modified* its benefits *in return for adherence to programs of health promotion*. This means that penalty-based Medicaid programs can reduce benefits for obese or overweight beneficiaries without violating HIPAA, as long as the reduction is contingent upon beneficiaries' failure to adhere to weight-loss regiments deemed appropriate by their doctors.

However, the penalty-based programs still have to comply with five additional requirements under HIPAA.[146] First, the amount of the reward or penalty may not exceed 20% of the cost of coverage,[147] so as not to effectively deny coverage for a beneficiary who fails to adhere to a wellness program requirement because of a health factor.[148] Second, the program must be "reasonably designed to promote health or prevent disease."[149] Third, beneficiaries must be allowed to qualify for the reward under the wellness program at least once a year.[150] Fourth, the reward must be available to all similarly situated individuals; specifically, the program must offer a "reasonable alternative standard" to participants for whom it is unreasonably difficult to meet regular standards because of a medical condition or for whom it is medically inadvisable to attempt to do so.[151] Finally, the fifth requirement is that all wellness-program materials disclose the availability of the reasonable alternative standard.[152]

Under the HIPAA nondiscrimination regulations, it is easy to conceive of potential penalty-based wellness programs that target obese individuals by

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143 *Id.* (emphasis added).

144 *Id.*

145 SOLOMON, *supra* note 102, at 2–3.

146 26 C.F.R. § 54.9802-1(f)(2) (2007).

147 *Id.* § 54.9802-1(f)(2)(i).

148 Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. at 75,018.

149 26 C.F.R. § 54.9802-1(f)(2)(ii).

150 *Id.* § 54.9802-1(f)(2)(iii). Although the statute says "reward," this does not mean reward in terms of reward-based systems only. *See* Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. at 75,018 (using the term "reward" to mean reward or penalty).

151 26 C.F.R. § 54.9802-1(f)(2)(iv).

152 *Id.* § 54.9802-1 (f)(2)(v).

making weight a health factor upon which the program is based. Indeed, West Virginia's Medicaid program probably complies with all five HIPAA requirements for wellness programs. It is unclear from available data whether the state program meets the first requirement—not exceeding 20% of the cost of coverage.[153] However, the program does not *effectively deny* treatment for obese beneficiaries because benefits are reduced to a minimum, not removed completely. Regarding the second requirement, although the statute states that the program cannot be overly burdensome, the legislative history indicates that this provision is meant to encourage experimentation by promoting wellness, and therefore only prohibits "bizarre, extreme, or illegal requirements."[154] Under this high threshold, it is unlikely that West Virginia's program, which requires beneficiaries to comply with their doctors' recommendations, is not "reasonably" designed to promote health. The third requirement is satisfied because beneficiaries are allowed to qualify for the enhanced benefit package annually.[155] The fourth requirement, that a reasonable alternative exist for beneficiaries who are unable to comply, is potentially satisfied in two ways. Initially, members are not obligated to sign the membership agreement, and therefore can "choose" the basic package if they feel the requirements of complying with the membership agreement are too stringent. Also, if beneficiaries sign the agreement and fail to fulfill their obligations, their removal to the basic benefit plan is not automatic, but "subject to good cause."[156] Finally, the fifth requirement, that beneficiaries be made aware of this "reasonable alternative," is presumably satisfied by disclosures made in distributed Medicaid materials.[157]

States will have few problems creating penalty-based wellness programs that comply with HIPAA nondiscrimination provisions. Programs that do not specifically target an obese or overweight individual, or violate the five additional requirements under HIPAA, are generally legally sound so long as reductions in benefits are contingent upon obese beneficiaries' failure to

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[153] For available data on West Virginia's State Plan Amendment, see W. Va. Dep't of Health & Human Resources, West Virginia Medicaid, http://www.wvdhhr.org/bms (last visited Sept. 19, 2008), and click on either the "BMS Medicaid Redesign Mountain Health Choices" or the "West Virginia State Plan Amendment" link.

[154] Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. at 75,018.

[155] Letter, *supra* note 3, attach. 2, at 1.

[156] *Id.*

[157] To see a copy of the "Notice to Members" presumably distributed to beneficiaries, see W. Va. Dep't of Health & Human Resources, Important Notice About Changes to Your Medicaid Benefits (Apr. 17, 2007), http://www.wvdhhr.org/bms/oAdministration/Medicaid_Redesign/redesign_NoticeMembers_MHC.pdf.

adhere to weight-loss regiments deemed appropriate by their doctors. Therefore, it is unlikely that obese beneficiaries covered by Medicaid wellness programs structured under HIPAA will succeed in arguing that the programs discriminate against them.

However, the Equal Employment Opportunity Commission (EEOC), a federal agency with the purpose of ending discrimination by employers and federal agencies,[158] made it clear in an informal discussion letter that compliance with HIPAA does not mean that wellness programs comply with other nondiscrimination laws.[159] Specifically, the EEOC noted that wellness programs that limit benefits based on a disability would violate the ADA.[160] This Comment next examines potential disability discrimination claims that obese beneficiaries could make under the ADA and § 504 of the Rehabilitation Act.

2. *ADA and § 504: Disability Discrimination*

Another form of health-based discrimination is disability discrimination, regulated by the ADA and § 504 of the Rehabilitation Act. This subsection begins by defining the ADA and § 504. It then examines potential claims brought under these laws, which depend on two issues: first, whether obesity is a disability; and second, whether state Medicaid programs discriminate against obese beneficiaries via penalty-based wellness programs.

a. *ADA and the Rehabilitation Act Defined*

The Rehabilitation Act of 1973[161] was the first federal statute granting disabled persons access to state and federal courts for disability discrimination suits.[162] Section 504 states that no qualified disabled individual will be denied access to or the benefits of any program or activity that receives federal funds solely because of his or her disability.[163] However, because § 504 is limited to organizations receiving federal assistance, it was not until the ADA was passed

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[158] 42 U.S.C. § 2000e-4 (2006). The EEOC enforces the federal laws prohibiting employment discrimination and oversees "federal equal employment opportunity regulations, practices, and policies." U.S. Equal Employment Opportunity Commission, Overview—Laws, Federal Equal Employment Opportunity (EEO) Laws, http://www.eeoc.gov/abouteeo/overview_laws.html (last visited Feb. 25, 2008).

[159] EEOC Informal Letter, Title VII / ADA: Health Insurance and Other Benefits (Apr. 4, 2001), http://www.eeoc.gov/foia/letters/2001/titlevii_ada_insurance_benefits.html.

[160] *Id.* (specifically noting AIDS, which is considered a disability).

[161] Pub. L. No. 93-112, 87 Stat. 355 (codified as amended at 29 U.S.C. §§ 701–797 (2006)).

[162] JOHN PARRY, HANDBOOK ON DISABILITY DISCRIMINATION LAW 80 (2003).

[163] 29 U.S.C. § 794(a) (2006).

in 1990 that federal law "prohibit[ed] discrimination by employers in the private sector, by places of public accommodation, or by state and local government agencies that [do] not receive federal aid."[164] Title II of the ADA applies to public entities,[165] including state and local governments, and their instrumentalities.[166] Therefore, because state Medicaid programs receive federal funding and are public entities, Medicaid beneficiaries can bring suit under § 504 or Title II.[167] Because Title II was modeled after § 504,[168] and because Title II generally requires public entities' compliance with § 504,[169] this Comment discusses relevant law in terms of Title II, which should be assumed to encompass § 504, except where otherwise noted.[170]

b. Is Obesity a Disability?

To bring an action under the ADA, an individual must have a disability.[171] For obese Medicaid beneficiaries, this means obesity would need to be characterized as a disability under the ADA before they could bring disability discrimination suits based on state Medicaid programs. Under the ADA, disability is defined as (1) a physical or mental impairment that substantially limits one or more of an individual's major life activities; (2) a record of such impairment; or (3) being regarded as having such impairment.[172] However, to file under Title II, the individual must also be a *qualified* individual with a disability, meaning an individual who, with or without reasonable

[164] Shoup, *supra* note 133, at 208–09.

[165] 42 U.S.C. §§ 12131–12134 (2006) (referred to as Subpart A). Subpart B of Title II applies to public transportation. *Id*. §§ 12141–12165.

[166] *Id*. § 12131(1).

[167] It is also possible for Medicaid beneficiaries to bring suit under Title III, which applies to public accommodations. *Id*. §§ 12181–12189. Additionally, they could sue Managed Care Organizations (MCOs) directly if the state chooses to have an MCO participate in its Medicaid program. However, since it is more likely that suits will be brought under Title II, *see* Alexander Abbe, "*Meaningful Access" to Health Care and the Remedies Available to Managed Care Recipients Under the ADA and Rehabilitation Act*, 147 U. PA. L. REV. 1161, 1175–83 (1999) (discussing the potential legal avenues beneficiaries have when denied benefits, and the potential for Title II as the avenue with the greatest promise), and since Title II is the "most prominent legal theory in suits against local governments," PARRY, *supra* note 162, at 80, this Comment focuses on Title II.

[168] *See* 28 C.F.R. § 41 (2007). Compare the language of 42 U.S.C. § 12132 with the language of 29 U.S.C. § 794(a) (2006).

[169] 42 U.S.C. §§ 12134(b), 12201(a).

[170] However, suits under § 504 may be preferential to those under Title II. PARRY, *supra* note 162, at 79–80 (discussing the application of *Board of Trustees of the University of Alabama v. Garrett*, 531 U.S. 356 (2001), which is interpreted to hold that individual claims for monetary damages under Title II are unconstitutional).

[171] 42 U.S.C. § 12101.

[172] *Id.* § 12102(2).

accommodations, meets the employer's eligibility requirements.[173] Therefore, for a Medicaid beneficiary to file under Title II, the beneficiary must have a disability and meet the financial qualifications of the state's Medicaid program.

While many people who are obese oppose being considered disabled based on their weight—a stigmatizing title they feel results from societal prejudice[174]—state and federal disability laws are currently the best, if not the only, means for legal redress available to obese individuals denied access to public entities.[175] From a legal perspective, however, the prospect of the typical overweight or obese Medicaid beneficiary being classified as disabled is unlikely.[176] Recall that a disability may be a (1) physical impairment that (2) substantially limits one or more (3) major life activities.[177] This three-pronged test creates a substantial hurdle to obese individuals being classified as disabled based on their weights.

As to the first prong, a physical impairment is any *physiological* disorder or condition affecting one or more specified body systems.[178] However, obesity is generally only considered an impairment if an individual is *morbidly* obese,[179] defined as one hundred pounds above or at least twice the ideal

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173 *Id.* § 12131(2).

174 SONDRA SOLOVAY, TIPPING THE SCALES OF JUSTICE: FIGHTING WEIGHT-BASED DISCRIMINATION 129–30 (2000).

175 *Id.* at 129.

176 However, it is not impossible. *See, e.g.*, Cook v. R.I. Dep't of Mental Health, Retardation, & Hosps., 10 F.3d 17 (1st Cir. 1993) (holding that a morbidly obese woman was disabled by her weight because her potential employer *perceived* her weight as substantially limiting her ability to work). Nonetheless, obese Medicaid beneficiaries will not succeed in arguing from a "perceived disability" standpoint because state Medicaid programs do not regard them as substantially limited in performing a major life activity; they are regarded as unhealthy based on their weight.

177 42 U.S.C. § 12102(2).

178 28 C.F.R. § 35.104(1)(i)(A) (2007). The body systems are neurological, musculoskeletal, special sense organs, respiratory, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine. *Id*.

179 *See, e.g.*, Andrews v. Ohio, 104 F.3d 803, 809 (6th Cir. 1997) (noting that the "only case which explicitly discusses the applicability of the Rehabilitation Act or the [ADA] to a person who is merely 'overweight' without being obese is *Tudyman v. United Airlines*, 608 F. Supp. 739 (C.D. Cal. 1984)," which dealt with a male bodybuilder with too much muscle to meet the height-weight requirements for becoming a flight attendant); Smaw v. Va. Dep't of State Police, 862 F. Supp. 1469, 1472–73, 1475 (E.D. Va. 1994) ("[I]t remains unclear whether simple obesity falls within the broad sweep of the definition of physical impairment [under the Rehabilitation Act] . . . . The case law and the regulations both point unrelentingly to the conclusion that a claim based on obesity is not likely to succeed under the ADA."); 29 C.F.R. pt. 1630, app. § 1630.2(j) (2007) ("[E]xcept in rare circumstances, obesity is not considered a disabling impairment."); Letter from Deval Patrick, Assistant Att'y Gen., Civil Rights Division, to Rep. Mark E. Souder, U.S. House of Representatives (Mar. 14, 1996), *available at* http://www.usdoj.gov/crt/foia/cltr184.txt ("Being overweight is generally not, by itself, an impairment. On the other hand, severe obesity . . . is an impairment.").

weight.[180] Furthermore, even if an individual is morbidly obese, this condition is not considered a physical impairment under the ADA if the condition is not actually or perceived to be physiologically caused.[181] Physiological causes for obesity—as opposed to voluntary nonphysical causes such as overeating—include hypertension, a thyroid disorder,[182] or dysfunctions of either the metabolic system or the "neurological appetite-suppressing signal system."[183] Because beneficiaries generally must have morbid obesity that is physiologically caused, many people affected by penalty-based wellness programs designed to incentivize weight loss will not be considered disabled under the ADA.

The second and third prongs of the disability test are best analyzed together for purposes of examining the legality of penalty-based wellness programs. Regarding the second prong, a substantial limitation is "an impairment that prevents or *severely* restricts the individual from doing activities that are of *central* importance to *most people's* daily lives. The impairment's impact must also be *permanent* or long term."[184] Under the third prong, major life activities are "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."[185] The third prong of the disability test, regarding major life activities, has been interpreted broadly by the Supreme Court, in *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, to include a variety of activities.[186] For example, the Supreme Court found major life activities to include "household chores, bathing, and brushing one's teeth," all of which can be affected by a wide

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[180] Natasha Benn, *Obesity Lawsuits Loom*, LEGAL TIMES, May 2007, at 1, 1.

[181] *Id.*; *see, e.g.*, EEOC v. Watkins Motor Lines, Inc., 463 F.3d 436, 442–43 (6th Cir. 2006) (holding that an individual must prove his obesity has a physiological cause to constitute an impairment under the ADA). This view is consistent with other government agency approaches to defining obesity as a disability. For example, one way for individuals to receive Medicaid benefits is to qualify for Social Security Income. 42 U.S.C. § 1396a(a)(10)(A)(i)(II). "Thirty-two states and the District of Columbia provide Medicaid eligibility to people eligible for Supplemental Security Income (SSI) benefits. In these States, the SSI application is also the Medicaid application." Social Security Online, Program Development & Research, Medicaid Information (Jan. 14, 2008), http://www.socialsecurity.gov/disabilityresearch/wi/medicaid.htm. In 1999, the Social Security Agency (SSA) removed obesity as a listed impairment, but SSA policies dictate that obesity can still be considered an impairment if it is medically determinable, severe, and meets or equals the requirements of listed impairments. Social Security Ruling, SSR 02-1p; Titles II and XVI: Evaluation of Obesity, 67 Fed. Reg. 57,859, 57,861 (Sept. 12, 2002).

[182] EEOC COMPLIANCE MANUAL § 902.2(c)(5)(ii) (2006).

[183] *See* Cook v. R.I. Dep't of Mental Health, Retardation, & Hosps., 10 F.3d 23 (1st Cir. 1993).

[184] Toyota Motor Mfg., Ky., Inc. v. Williams, 534 U.S. 184, 198 (2002) (emphasis added).

[185] 28 C.F.R. § 35.104(2) (2007).

[186] PARRY, *supra* note 162, at 12.

variety of impairments.[187] At first this appears to benefit morbidly obese beneficiaries wishing to bring suit, allowing greater latitude as to which activities affected by their obesity will be deemed "major life activities." However, in the same opinion the Supreme Court "took a much stricter view of what constitutes a substantial limitation" of these activities, limiting the second prong of the disability test.[188] For example, the Court stated that impairments causing an individual to "avoid sweeping, to quit dancing, to occasionally seek help dressing, and to reduce how often she plays with her children, gardens, and drives long distances" do not substantially limit major life activities.[189] This narrower view of substantial limitation negates any latitude as to what constitutes major life activities, making it much harder for morbidly obese beneficiaries to show that their condition affects their lives in such a drastic way as to be considered a disability.

Additionally, the substantial limitation requirement of the second prong was made even harder to meet by a "trilogy of Supreme Court decisions"[190]—*Sutton v. United Air Lines, Inc.*,[191] *Albertson's, Inc. v. Kirkingburg*,[192] and *Murphy v. United Parcel Services, Inc.*[193] This trilogy "concluded that for persons who are benefiting from measures to correct for or mitigate an impairment, the decision as to whether an impairment constitutes a substantial limitation must be made by assessing the impairment in its *mitigated or corrected state*."[194] For example, whether nearsighted individuals are disabled should be determined based on their condition when wearing eyeglasses or contact lenses.[195] This implies that if morbidly obese Medicaid beneficiaries benefit from any measure that would lessen their condition, such as diet and exercise regiments, or even surgery, the determination of whether the condition is substantially limiting must be based on their benefited states.[196] This line of reasoning further weakens the legal positions of morbidly obese Medicaid beneficiaries.

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[187] *Id.* (citing *Toyota*, 534 U.S. at 202).
[188] *Id.*
[189] *Id.*
[190] PARRY, *supra* note 162, at 10 (citations omitted).
[191] 527 U.S. 471 (1999).
[192] 527 U.S. 555 (1999).
[193] 527 U.S. 516 (1999).
[194] PARRY, *supra* note 162, at 10–11 (emphasis added).
[195] *Sutton*, 527 U.S. at 472.
[196] *See id.*

An obese individual is only disabled under this three-pronged test if he is morbidly obese, his obesity is physiologically caused, and he can show that his morbid obesity substantially limits a major life activity—a test made stricter in recent years by *Toyota* and cases mandating assessment in a mitigated state.[197] This is a formidable test for most overweight and obese Medicaid beneficiaries to pass, making the likelihood that they can bring suit for disability discrimination under state penalty-based wellness programs slim.[198]

c. When Does a Public Entity Discriminate?

Assuming a Medicaid beneficiary is able to pass the three-pronged disability test, the individual still has to show that a public entity discriminated against him, based on his disability, to file a claim under Title II.[199] For purposes of this Comment, this means an individual must show that a state Medicaid program disallowed his participation or recovery of benefits at least in part because of his obesity.

To establish a claim under Title II, an individual must show the following: "(1) that [he] is a qualified individual with a disability, (2) who was excluded from participation in or was denied benefits of services, programs, or activities of a public entity, and (3) that such discrimination was the result of the individual's disability."[200] Additionally, case law creates a fourth requirement—that an individual shows he was denied "meaningful access" to the public entity's benefits or services.[201]

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[197] *See supra* notes 179–94 and accompanying text.

[198] On September 25, 2008, the President signed legislation that revised § 12101 with respect to what constitutes a disability under the American's with Disabilities Act. *See* ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (to be codified at 42 U.S.C. § 12101 *et seq*). With respect to this Comment, these modifications generally expand the scope of what is considered a disability in two ways. First, the modifications reject the Supreme Court's holding in *Toyota* regarding its narrow interpretation of the term "substantially limits." *See id.* § 4, 122 Stat. at 3555–56. Second, the modifications reject the ruling in *Sutton* regarding the use of mitigating factors to determine if someone is disabled. *See id.* Therefore, these changes to the ADA create a greater likelihood that obesity will be considered a disability in the future.

[199] *See* 42 U.S.C. § 12132 (2006). "[N]o qualified individual with a disability shall, by reason of such disability, *be excluded* from participation in or *be denied* the benefits of the services, programs, or activities of a public entity, or be *subjected to discrimination* by any such entity." *Id.* (emphasis added).

[200] Ann K. Wooster, Annotation, *When Does a Public Entity Discriminate Against Disabled Individuals in Provision of Services, Programs, or Activities Under the Americans with Disabilities Act*, 163 A.L.R. FED. 339 § 2(a) (2000). To establish a claim under § 504, an individual must meet the three-pronged test required under Title II, and must also show that the entity receives federal financial assistance. *See, e.g.*, Lovell v. Chandler, 303 F.3d 1039, 1052 (9th Cir. 2002), *cert. denied*, 537 U.S. 1105 (2003).

[201] Alexander v. Choate, 469 U.S. 287, 301–02 (1985). This is a § 504 case and not a Title II case.

An examination of the case law regarding public entity discrimination by healthcare providers reveals two trends that, when applied, are likely to hold that lifestyle-contingent wellness programs are nondiscriminatory. The first trend is that cases where entities have been found to discriminate generally fall into one of two types. One type is where entities, such as Medicaid programs, have treated *one* disabled group differently from all others.[202] Wellness programs such as West Virginia's do not fall into this category because they do not target a particular disabled group, such as the morbidly obese or the blind, but instead apply to all beneficiaries who do not maintain healthy lifestyles. The other situation where healthcare entities are found to discriminate is where the entity treats *all* disabled persons differently from others.[203] This too would not apply to wellness programs such as West Virginia's because they do not target all disabled persons who receive reduced benefits, but instead focus only on those individuals who choose not to maintain healthy lifestyles. This case law is consistent with the ADA itself, which states that Title II is not intended to prevent or hinder risk assessment practices typically employed by insurers.[204] Therefore, as with the HIPAA regulations, entities, including Medicaid programs, can choose to treat differently situated people differently without technically discriminating against them.[205]

The second trend in the case law that tends to favor lifestyle-contingent wellness programs has to do with the "meaningful access" requirement. When the requirement was first conceived in *Alexander v. Choate*,[206] the Supreme Court examined three factors to determine if meaningful access to healthcare existed: (1) whether the entity's policies had a "particular exclusionary effect"; (2) whether the policies were facially neutral; and (3) whether there was evidence that the disabled would be unable to benefit meaningfully from the entity's policy.[207] While exactly what constitutes meaningful access remains

[202] *See, e.g.*, McNally v. Prison Health Servs., 46 F. Supp. 2d 49 (D. Me. 1999) (denying summary judgment for a prisoner suffering from AIDS against a detention facility whose policy was to treat those suffering from AIDS differently than other detainees), *recons. denied*, 52 F. Supp. 2d 147.

[203] *See, e.g.*, *Lovell*, 303 F.3d 1039 (holding that the exclusion of disabled persons from participation in a state healthcare program because they were disabled was discrimination by a public entity under § 504).

[204] Abbe, *supra* note 167, at 1175–76 (discussing the language of 42 U.S.C. § 12201(c)). This statement also technically applies to Titles I and III, but its application to these titles is negated in part by the Subterfuge Clause of Title V: "[42 U.S.C. § 12201(c)] shall not be used as a subterfuge to evade the purposes of subchapter *I and III* of this chapter." 42 U.S.C. § 12201(c) (emphasis added).

[205] *See, e.g.*, Hines v. Sheehan, 1995 WL 463685 (D. Me. July 26, 1995) (holding that a Medicaid program providing reimbursement for a drug to persons with one illness and not providing the same service to others is not disability discrimination—it is the state choosing to deal with different illnesses differently).

[206] 469 U.S. 287 (1984).

[207] *Id.* at 302.

unclear,[208] even the most generous interpretations of the requirement favor lifestyle-contingent wellness programs. The broadest understanding of meaningful access is "adequate access," meaning that when access to a public entity's services or benefits is inadequate for a disabled individual, the entity has committed disability discrimination.[209] Under this interpretation, it is unlikely that wellness programs, like West Virginia's, will be deemed to deny adequate access to Medicaid benefits. West Virginia's program does not remove all benefits from beneficiaries, but instead limits them to the minimum available.[210] Additionally, these programs only apply to optional groups of beneficiaries under federal law.[211] It is doubtful that courts will find that these programs deny obese beneficiaries adequate access to benefits when they are receiving the same benefits as many other nonmandatory beneficiaries, and when the state is not even required to extend benefits to them in the first place.

States will not have any problems creating penalty-based wellness programs that comply with Title II. Obese beneficiaries are unlikely to even be considered disabled under the disability test of Title II. Further, because the case law tends to support lifestyle-contingent wellness programs with respect to their ability to limit access, engage in risk assessment, and treat differently situated persons differently, obese Medicaid beneficiaries will find it difficult to show that these programs discriminate against them based on their weight as a disability.

B. The Equal Protection Clause and Discrimination

Obese beneficiaries may also attempt to show discrimination by state Medicaid programs under the Equal Protection Clause of the United States Constitution.[212] This Comment briefly examines this potential legal avenue only to dispel the belief that such claims would be valid.

The Equal Protection Clause, found in the Fourteenth Amendment to the Constitution, generally prohibits states from denying persons equal protection under their laws.[213] The clause effectively denies states the right to

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[208] *See* Abbe, *supra* note 167, at 1187–94 (discussing the variety of approaches taken by courts in defining and interpreting the term "meaningful access").
[209] *Id.* at 1194.
[210] *See supra* note 104 and accompanying text.
[211] *See supra* note 106 and accompanying text.
[212] U.S. CONST. amend. XIV, § 1.
[213] *See id.* ("No State shall . . . deny to any person within its jurisdiction the equal protection of the laws.").

discriminate by requiring that all similarly situated persons be treated similarly.[214] Equal protection under the law does not literally mean that all persons must be treated equally; those who are differently situated can be treated differently.[215] For example, if a state prohibits black students from attending a public school because of their race, this would violate the Equal Protection Clause because the school would be treating a similarly situated class of students differently with discriminatory intent.[216] However, if a state passes a law that has a disparate impact on a class of persons, but there is an independently legitimate reason for the impact and therefore no legislative intent to discriminate, the Equal Protection Clause would not be violated.[217]

While there is no single standard for determining when a state denies equal protection, the general rule is that a challenger must show that the law is not "rationally related" to some legitimate government interest.[218] States are required to show more than a rational basis when discrimination occurs against a "suspect class," or when a fundamental right is implicated.[219] The Supreme Court has generally declined to extend the reach of the "suspect class" concept beyond race and functionally equivalent classes.[220] Additionally, fundamental rights for purposes of the Equal Protection Clause are limited to rights explicitly or implicitly granted in the Constitution,[221] such as voting[222] or the right to interstate travel.[223]

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214 *See, e.g.*, City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 439 (1985) ("The Equal Protection Clause of the Fourteenth Amendment commands that no State shall 'deny to any person within its jurisdiction the equal protection of the laws,' which is essentially a direction that all persons similarly situated should be treated alike.").

215 *See, e.g.*, Tigner v. Texas, 310 U.S. 141, 147 (1940) ("The equality at which the 'equal protection' clause aims is not a disembodied equality . . . . The Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same.").

216 *See* Brown v. Bd. of Educ., 347 U.S. 483 (1954).

217 *See* Washington v. Davis, 426 U.S. 229 (1976) (holding that a District of Columbia police department's use of a verbal skills test for eligiblity was not discriminatory under the Equal Protection Clause because the department did not intend to discriminate, even though African Americans were disproportionately affected).

218 *See, e.g.*, Schweiker v. Wilson, 450 U.S. 221, 230 (1981).

219 *See, e.g.*, Romer v. Evans, 517 U.S. 620, 631 (1996) ("[I]f a law neither burdens a fundamental right nor targets a suspect class, we will uphold the legislative classification so long as it bears a rational relation to some legitimate end."). There is an intermediate level of scrutiny applied to cases dealing with quasi-suspect classes such as gender. *See, e.g.*, United States v. Virginia, 518 U.S. 515 (1996).

220 *See, e.g.*, City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 440 (1985) (discussing how strict scrutiny applies to classes of race, alienage, or national origin).

221 *See* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33–35 (1973).

222 *See* Bush v. Gore, 531 U.S. 98, 104 (2000) (per curiam).

223 *See* Saenz v. Roe, 526 U.S. 489 (1999).

Because obese individuals are not a suspect class and there is no constitutional right to healthcare—indeed, the United States does not have a national healthcare system—the rational basis test applies to state laws that restrict the Medicaid benefits of obese people because of their inability to lose weight. Under this test, taking West Virginia's program as an example, it is doubtful that penalty-based wellness programs deny beneficiaries equal protection under the law. First, the program does not specifically apply to obese individuals, but instead applies to all those who fail to conform to their physician-recommended lifestyle programs. Second, the state's interest in reducing outrageous state spending and improving citizens' health is likely to be found legitimate. Third, this legitimate government interest is not irrationally related to the requirement that people opt to live healthier lifestyles or agree that they will receive less benefits.

IV. PENALTY-BASED WELLNESS PROGRAMS SHOULD NOT BE IMPLEMENTED DESPITE THEIR LEGALITY

After examining the many legal avenues available to obese Medicaid beneficiaries, their ability to legally challenge lifestyle-contingent wellness programs is doubtful. Although Medicaid is typically viewed as an entitlement program, the absence of an express private right of action contradicts this popular impression.[224] This view is further weakened by the encouragement of § 1115 waivers to circumvent federal Medicaid requirements, and the policy changes under the DRA, both of which make it all too easy for penalty-based programs to meet legal requirements that are inconsistent with the original intent of the FMA. Similarly, while denying otherwise qualified beneficiaries benefits based on weight appears discriminatory, the provisions of HIPAA, § 504, the ADA, and the Equal Protection Clause reflect the views of modern society that weight is not a disability, that risk assessment based on weight is a sound economic practice, and that as long as states treat similarly situated persons similarly, they are not discriminating.[225]

While the implementation of these programs may be legally sound, states should not adopt them with the goal of reducing obesity-related Medicaid costs. There are several reasons why these programs may be unsuccessful at lowering costs, and may even have the opposite financial result. Additionally, even if these programs do have the intended cost-reduction effect, there exist

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[224] *See supra* Part III.B.1.

[225] *See supra* Part III.B.2.

sound policy reasons why they *should not* be implemented even though it appears they *could* be.

A. Will Penalty-Based Programs Reduce Costs?

The purpose of most state Medicaid programs that use DRA benefit packages or § 1115 waivers is to reduce costs.[226] Undeniably, West Virginia's plan was implemented with this idea in mind.[227] Therefore, lifestyle-contingent Medicaid programs are based on the assumption that obese individuals can respond to financial incentives: the threat of losing enhanced benefit coverage will encourage people to lose weight, and therefore reduce costs. However, if this assumption is not true—if obese Medicaid beneficiaries do not respond to such financial incentives—lifestyle-contingent programs will not only fail to reduce obesity among beneficiaries, but will likely result in increased Medicaid costs.[228]

Basic economic theory suggests that economic incentives, such as those provided by West Virginia's program, will encourage obese individuals to lose weight.[229] Assuming consumers are reasonable, if the cost of a product increases, consumers will buy less of that product; similarly, if the cost of a product decreases, consumers will buy more. Applying this same rationale to penalty-based wellness programs, if the cost of being obese increases in the form of a reduction in health benefits, then beneficiaries will lose weight to obtain those benefits. Additionally, economic theory suggests that these programs will work because they force obese individuals to pay for their poor health choices.[230] This is known as internalizing an externality.[231] In this case, obesity creates an externality by imposing high external costs on the state, federal government, and taxpayers who pay for the medical bills that result from obesity.[232] Only by forcing obese beneficiaries to pay for their behavior

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[226] *See supra* text accompanying notes 89–97.

[227] *See supra* note 7 and accompanying text.

[228] These cost increases would result from "higher administrative costs." SOLOMON, *supra* note 102, at 6.

[229] *See* FINKELSTEIN & ZUCKERMAN, *supra* note 42, at 195 ("Economic theory suggests that financial incentives can motivate people to alter a behavior by changing the costs and benefits associated with that behavior.").

[230] Jay Bhattacharya & Neeraj Sood, *Health Insurance and the Obesity Externality* 24–26 (Nat'l Bureau of Econ. Res., Working Paper No. 11529, 2005), *available at* http://www.rand.org/pubs/working_papers/2006/RAND_WR340.pdf.

[231] ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 46 (2004) (defining an externality as an external cost).

[232] Bhattacharya & Sood, *supra* note 230, at 26–29.

do they internalize or become aware of the costs of their decisions, and become incentivized to lose weight.[233]

While the idea that these incentives will result in weight loss may be sound in theory, there is little evidence that they will work in practice. There are studies suggesting that rewards are not likely to incentivize Medicaid beneficiaries to change their behavior.[234] Furthermore, there are no available studies regarding penalties, or other evidence, suggesting that penalties will work,[235] especially when it comes to obesity.[236]

There are several theories as to why financial incentives for health-related behavior may not be effective for Medicaid beneficiaries or people with limited financial means. One simply questions whether "widespread changes in individual behavior are possible without eliminating societal barriers to healthy food choices and active lifestyles, a major challenge in some low-income communities."[237] Another is that, due to evolutionary biology, economic insecurity naturally causes weight gain as a result of the inherent propensity to eat and store food when it is limited.[238] A similar theory is that the human genetic makeup developed during a time when food was scarce, and therefore *everyone*, not just those with limited means, is hardwired to overeat when food is present, due to an unconscious assumption that food will again become scarce.[239] However, populations that evolved from societies most likely to go without food for long periods of time—like those in harsh desert climates—have a greater likelihood of engaging in overeating behavior.[240]

Furthermore, there are studies that directly contradict the premise of cost-saving behavior upon which wellness programs like West Virginia's are based.

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[233] *Id.* at 24–26.

[234] *See* REDMOND ET AL., *supra* note 2, at 2 ("[T]here is little evidence that financial *rewards* will lead Medicaid beneficiaries to obtain more preventive services. Few rigorous studies have been conducted . . . . None of these reviews focus specifically on incentives provided to Medicaid beneficiaries.").

[235] SOLOMON, *supra* note 102, at 6. Additionally, since West Virginia's is the first program of its kind, studies analyzing penalty programs' cost-effectiveness have not been prepared.

[236] REDMOND ET AL., *supra* note 2, at 3–4 (noting the particular difficulty of economic incentives to change obesity-related behavior).

[237] *Id.*

[238] Trenton G. Smith et al., *Why the Poor Get Fat: Weight Gain and Economic Insecurity* 17–18 (Wash. State Univ. Sch. of Econ. Sci. Working Paper Series, Working Paper No. 16, 2007).

[239] FINKELSTEIN & ZUCKERMAN, *supra* note 42, at 248 n.15; Trenton G. Smith, *Reconciling Psychology with Economics: Obesity, Behavioral Biology, and Rational Overeating* 5–16 (Wash. State Univ. Sch. of Econ. Sci. Working Paper Series, Working Paper No. 4, 2006), *available at* http://www.ses.wsu.edu/PDFFiles/WorkingPapers/Insecurity033007.pdf.

[240] FINKELSTEIN & ZUCKERMAN, *supra* note 42, at 54.

For example, a recent study found no evidence to support the theory that "[i]n the absence of insurance, individuals have strong incentives to engage in behaviors that help prevent injury and illness."[241] This means that the threat of losing insurance coverage or benefits does not drive individuals to alter their behaviors in order to maintain or access insurance coverage or benefits. Additionally, a 2008 study focusing on obese individuals and smokers in the Netherlands showed that over their lifetimes these groups actually cost *less* than people who were not overweight and did not smoke, calling into question the fundamental rationale behind wellness programs.[242]

While it is unclear exactly why obese Medicaid beneficiaries are unlikely to respond to economic incentives, what is clear is that there is not enough conclusive economic data to support implementation of penalty-based wellness on the premise that they will reduce costs.

B. Using Weight as a Proxy for Health

In attempting to reduce state Medicaid costs, programs like West Virginia's operate under the assumption that if beneficiaries lose weight they will cost the state less in healthcare expenditures. This assumption itself is based on the premise that weight loss will make beneficiaries healthier. While it is well-founded that obesity is related to an increased risk for a variety of health problems,[243] this fact does not prove that all people who are overweight are unhealthy.[244] Several studies in recent years have shown that the "dangers of moderate fat have been exaggerated and misrepresented," with one study in particular showing that "being 20 to 30 pounds 'overweight' resulted in no increased mortality."[245] In contrast to the view that fat itself causes poor

[241] Inas Rashad & Sara Markowitz, *Incentives in Obesity and Health Insurance* 2 (Nat'l Bureau of Econ. Res., Working Paper No. 13113, 2007).

[242] Pieter H.M. van Baal et al., *Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure*, 5 PLoS MED. 242 (2008), http://medicine.plosjournals.org/perlserv/?request=get-pdf&file=10.1371_journal.pmed.0050029-L.pdf; *see also* Editorial, *Survival of the Fattest*, L.A. TIMES, Feb. 9, 2008, at A20; Arthur Garson, *Prevention is Good Medicine, but It's Not a Fiscal Panacea*, USA TODAY, Feb. 13, 2008, at 11A. The reason for this disparity in costs is that smokers and obese persons have shorter average lifespans than healthier persons. *See* van Baal et al., *supra*, at 242.

[243] *See supra* note 26 and accompanying text.

[244] *See* SOLOVAY, *supra* note 174, at 203–07 (discussing the erroneous association between increased mortality and being *moderately* overweight).

[245] *Id.* at 203.

health, another theory posits that fitness level, and not weight alone, determines an individual's relative health.[246]

In addition to the contrasting views about health and weight, another issue is the approach taken to determine who is overweight. While "[v]irtually all social science research related to obesity uses body mass index (BMI), . . . there is wide agreement in the medical literature that such measures are seriously flawed because they do not distinguish fat from fat-free mass such as muscle and bone."[247] If the BMI method is seriously flawed, mandating that obese beneficiaries lose weight, with BMI used as a proxy for weight loss, will result in beneficiaries who are perfectly healthy being forced to lose weight. Therefore, the general agreement on the flawed nature of BMI critically calls into question its use by penalty-based wellness programs to determine which beneficiaries are overweight.

Finally, even assuming that BMI is an accurate predictor of health, how are state Medicaid programs going to determine which beneficiaries are overweight because they lead unhealthy lifestyles, and which beneficiaries are overweight because of other intervening factors? Recent medical research has concluded that genetics play a prominent role in determining an individual's weight.[248] Indeed, "several studies on the genetic component of obesity find that as much as 70 percent of the differences between individuals' body weights can be attributed to biological factors. This genetic component helps explain why there are strong racial/ethnic tendencies toward excess weight."[249] Although researchers recognize the equally prominent role that the environment plays in determining an individual's weight,[250] studies on adopted children show that genes play a stronger role than environment when it comes

[246] *See* LAURA FRASER, LOSING IT: FALSE HOPES AND FAT PROFITS IN THE DIET INDUSTRY 252–55 (1998) (referring to a study by the Cooper Institute for Aerobics Research).

[247] John Cawley & Richard V. Burkhauser, *Beyond BMI: The Value of More Accurate Measures of Fatness and Obesity in Social Science Research* 1 (Nat'l Bureau of Econ. Res., Working Paper No. 12291, 2006), *available at* http://www.nber.org/papers/w12291.pdf?new_window=1. For more information on the inaptness of BMI as an indicator of health, see Abel Romero-Corral et al., *Association of Bodyweight with Total Mortality and with Cardiovascular Events in Coronary Artery Disease: A Systematic Review of Cohort Studies*, 368 LANCET 666 (2006); Joshua J. Ode et al., *Body Mass Index as a Predictor of Percent Fat in College Athletes and Nonathletes*, 39 MED. & SCI. SPORTS & EXERCISE 403 (2007).

[248] FINKELSTEIN & ZUCKERMAN, *supra* note 42, at 52–55.

[249] *Id.* at 52 (footnote omitted).

[250] *See id.* at 53 ("Although weight and the likelihood of being obese are influenced by genetics, environment also plays a major role. For example, studies have found that children's diet and exercise habits follow those of their parents.").

to predicting their BMIs.[251] Therefore, penalty-based programs implemented for the purpose of changing beneficiaries' behavior in order to reduce their weights are unlikely to be successful if they cannot discern which individuals are not able to lose sufficient weight through behavior changes.

C. The Nanny State: Should the Government Tell Us What to Eat?

Even if penalty-based wellness programs succeed in reducing costs, programs that dictate what people can eat and how many times a day they should exercise give the government a primary role in managing beneficiaries' daily lives. Some would conclude that this sort of activity makes state governments into "nanny states,"[252] a term that refers to governments that take an overly zealous paternalistic role in their citizens' lives under the guise of protecting them from themselves.[253] While certain paternalistic actions by the government—such as Social Security[254]—are certainly welcomed as fundamental aspects of our culture, the core concern is that these actions "conflict[] with American values" because they result in "government oversight of the personal lives of dependent adults."[255] Indeed, the initial draft of West Virginia's Member Agreement read as follows:

> I understand that it is my responsibility to do what is necessary to stay healthy. I understand that smoking, using drugs illegally, drinking too much alcohol, and *being over weight are bad for my health*. *I promise to try not to do these things*. I will go to the special programs as my health care provider advises in order to improve and maintain my health *including exercise and nutrition programs*.[256]

While this exact language has since been removed, physicians still have the state-approved ability to design health promotion programs for patients, effectively determining what they are able to eat and how much they should exercise, based on their medical opinions. Such an intrusive role by the government—especially into the lives of those who have limited means and

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[251] *Id.* at 247 nn.12–13.

[252] This now well-known term was coined in 1965 in England. DAVID HARSANYI, NANNY STATE: HOW FOOD FASCISTS, TEETOTALING DO-GOODERS, PRIGGISH MORALISTS, AND OTHER BONEHEADED BUREAUCRATS ARE TURNING AMERICA INTO A NATION OF CHILDREN 7 (2007).

[253] *Id.*

[254] Lawrence M. Mead, *Telling the Poor What to Do*, PUB. INT., Summer 1998, at 97, 98.

[255] *Id.* at 111; *see also* David R. Buchanan, *Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health*, 98 AM. J. PUB. HEALTH 15, 15–20 (2008) (arguing that with regard to public health, less attention should be paid to justifying government intervention and more effort should be placed on increasing autonomy and justice).

[256] W. VA. DEP'T OF HEALTH & HUMAN RESOURCES, *supra* note 7, at 16 (emphasis added).

time to devote to meeting potentially lofty health objectives—should not be implemented without serious consideration of the potential effects.

CONCLUSION

Penalty-based wellness programs *should not* be implemented to reduce obesity-related Medicaid costs, which is not to say that these programs *cannot* be implemented. At first look, it may seem that an array of federal laws exists to protect individuals, such as obese Medicaid beneficiaries, from being denied benefits based on their weight. While these laws do exist,[257] their reach falls short of covering this group of individuals. This lapse in legal protection begins with the FMA itself, and the palpable absence of an express private right of action for beneficiaries.[258] Furthermore, the FMA is easily circumvented by politically encouraged options, such as § 1115 waivers and DRA benefit packages, both of which generally require only that programs retain coverage for mandatory Medicaid populations to obtain approval.[259] Similarly, while several legal protections are in place to prevent discrimination, the provisions of HIPAA, § 504, the ADA, and the Equal Protection Clause generally reflect the limited view that as long as states treat similarly situated persons similarly, they are not discriminating.[260] This lack of legal protection is made all the more prominent in a fat-hating society eager to make obese and overweight persons pay for the costs they impose on state and federal governments, as well as taxpayers.[261]

However, the fact that penalty-based Medicaid wellness programs are legally sound does not justify their implementation to reduce obesity-related costs. The overwhelming absence of economic support for the theory that obese persons will respond to the threat of losing enhanced benefits by losing weight indicates that these programs will not achieve the cost-effectiveness for which they strive.[262] Additional uncertainty about the relationship between health and weight, as well as how excessive weights are defined, further undermines the rationale behind these programs.[263] Finally, the intrusive and omnipotent role that physicians—and, by extension, the states—would play in

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[257] *See supra* Parts II, III.
[258] *See supra* Part II.A.
[259] *See supra* Part II.B.
[260] *See supra* Part III.
[261] *See supra* note 57 and accompanying text.
[262] *See supra* Part IV.A.
[263] *See supra* Part IV.B.

the daily lives of obese beneficiaries via these mandatory health programs stretches the proper role of the American government.[264]

Perhaps the result of denying drug and alcohol addicts Medicaid benefits in the 1990s best illustrates the devastating potential of programs, like West Virginia's, that regulate based on unsound economic incentive theories. Prior to 1994, addicts could receive Medicaid benefits because addiction was considered a disability.[265] However, based on increased costs associated with covering addicts, and the growing social and political belief that addicts should not be rewarded for their poor choices, addiction was removed from the list of per se disabilities.[266] The predominate theoretical justification was that loss of these benefits would incentivize addicts to get clean and turn their lives around.[267] However, this unfounded economic theory failed to accurately predict addicts' behavior, resulting in large populations of homeless and crime-driven junkies.[268] Much like obesity, this policy was founded on a legal but unproven theory of economic incentives being sufficiently strong to change a particular behavior. Given that no consensus exists as to what causes people to become overweight, and that several studies suggest these behaviors may be hardwired into our behavioral biology, adopting penalty-based wellness programs is a premature action with potentially harmful consequences for the affected beneficiaries.

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264 *See supra* Part IV.C.

265 Dru Stevenson, *Should Addicts Get Welfare? Addiction & SSI/SSDI*, 68 BROOK. L. REV. 185, 189 (2002).

266 *Id.* at 186, 190.

267 *Id.* at 195–97.

268 *Id.* at 196–202.

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