

# WORKPLACE WELLNESS: SOCIAL INJUSTICE

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## INTRODUCTION

Imagine coming to work one day to find that your employer is offering a new wellness program as part of its generous benefits package. This wellness program has attractive features, including discounted rates to the nicest fitness centers in town and free Fitbit monitors for all who choose to enroll. The enrollment process involves an online questionnaire that asks you to disclose personal information, including height, weight, and whether you have a family history of a number of diseases. Giving up this information makes you nervous as to what your employer will do with it, but you answer the questions anyway. Upon completing the online assessment, you learn that the wellness program also requires a quick and painless cheek swab, allowing the program to test for certain genetic information including the risk of several inheritable diseases. You get more anxious and wonder whether you should enroll at all. Your employer assures you that the wellness program is entirely voluntary. If you choose not to enroll, however, a surcharge of \$3000 per year will be deducted from your paycheck. In addition, you learn, if you opt out of the program you and your family would become ineligible for your employer's health insurance. Paying privately for your family's health insurance would cost you, you estimate, another \$18,300 per year.<sup>1</sup> Faced with the choice of enrolling in the wellness program or paying an additional \$21,000 per year for your informational privacy (which you are not confident is entirely secure anyway), you enroll in the wellness program and allow the cheek swab. At your next review, you are being let go, and as you later learn, so are all other employees with high cholesterol and a family history of heart disease.

This scenario is now more plausible than ever. Employers increasingly offer financial incentives to employees for providing health information or impose penalties for not doing so. Employees who refuse to provide that information effectively can be fined for their refusal to comply. Those fines may be unaffordable for many people, creating, in effect, a compulsory loss of health privacy. Simply providing that health information is not without its own costs, since doing so can lead to serious adverse consequences, given the limited privacy and anti-discrimination protections available in workplace wellness programs. As a result, an increasing number of employees face an

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1. This estimate was derived using the WebMD health insurance calculator on January 17, 2016, using a baseline income of \$100,000 for a family of three with the oldest family member being fifty years old in suburban Boston, MA. *Health Insurance Cost Calculator*, WEBMD, <http://www.webmd.com/health-insurance/insurance-costs/insurance-cost-calculator> (last visited Mar. 4, 2017).

unacceptable choice: provide personal health information that their employers can legally use against them or pay a penalty that they cannot afford. Given the hidden costs and inefficiencies of workplace wellness programs, their technological advancement, and strong federal policies of protecting employees from discrimination and privacy violations, it is critically important now to reassess the regulation and the value of workplace wellness programs.

This Article does just that, by explaining how this conflict arose, analyzing the challenges it presents, and suggesting practical next steps. In particular, it explores the recent legislation, enforcement guidance, and case law expanding the scope of incentivized workplace wellness programs and undercutting the privacy and anti-discrimination protections intended to protect employees from misuse of their confidential health data.

The Patient Protection and Affordable Care Act (ACA) expanded the scope of permissible workplace wellness program incentives, including financial penalties for employees who do not comply with them. Several forces drive the increasing adoption of such wellness programs, including rising health insurance rates, the Equal Employment Opportunity Commission (EEOC)'s guidelines expanding employers' powers to incentivize these programs, and case law affirming that expansion of power.

Although federal regulations require that these wellness plans be voluntary, the financial penalties associated with noncompliance suggest that the "voluntariness" is a legal fiction. Increasing numbers of employees must now choose whether to provide their employer with sensitive personal health data or pay a fine, in some cases 30% of the plan cost (over \$5000, on average).<sup>2</sup> Courts are ruling on the legality of these incentives, generally erring on the side of the employer, literally at the employee's expense. Recent judicial decisions have clarified that employers may also use a "safe harbor" provision in the Americans with Disabilities Act (ADA) to justify these wellness programs regardless of the incentives attached.

While employees may be financially compelled to provide this information, the privacy and employment risks of doing so are growing. A set of federal regulations including the ADA and the Genetic Information and Nondiscrimination Act (GINA) were designed in part to limit employers' ability to compel employees to provide sensitive

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2. *Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2016*, HENRY J. KAISER FAM. FOUND. (Sept. 14, 2016), <http://kff.org/interactive/premiums-and-worker-contributions/>.

health data at work.<sup>3</sup> In practice, this system is breaking down at the expense of employee privacy, effectively eviscerating the privacy and anti-discrimination protections that federal laws were designed to provide to employees. The social injustice inherent in this scheme, together with the less obvious risks and disadvantages of wellness programs raise questions about the wisdom of this trend.

There is an urgent need for scholarly attention to this issue. Federal agencies are developing new regulations to balance public and private interests in employee wellness incentives. For example, on October 30, 2015, the EEOC announced its plans to propose a rule clarifying that employers may penalize employees who do not provide information about their spouse's health information without violating the terms of GINA.<sup>4</sup> On April 20, 2015, the EEOC announced plans to propose a similar rule describing when an employee's disclosure of health-related information pursuant to an employee wellness plan is considered voluntary and therefore permissible under the ADA.<sup>5</sup> Final rules have not yet been issued.

This Article examines the extent to which the ACA and ADA/GINA are on a collision course when it comes to employee wellness programs. It contributes to the academic literature by bringing together legal, technological, and health policy data in order to comprehensively analyze the recent erosion of privacy and antidiscrimination protections that were enacted to protect employees from misuse of their confidential health information. While the potential benefits of workplace wellness programs are well understood, this Article also surveys some of their risks in order to provide a more balanced view of these programs for the benefit of scholars, employers and policymakers.

Part I of this Article examines the growth of workplace wellness programs, including the economic and regulatory drivers of that growth, as well as the technological advances such wellness programs encompass. Part II explores the risks of this growth, including several of the inefficiencies and potential social harms of these programs that undercut their perceived benefits. Part III examines the evolution of workplace wellness programs' regulatory landscape, including the in-

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3. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990); Genetic Information Nondiscrimination Act of 2008, 42 U.S.C.A. § 2000 (West 2016).

4. Genetic Information Nondiscrimination Act of 2008, 80 Fed. Reg. 66,853 (proposed Oct. 30, 2015).

5. Press Release, U.S. Equal Emp. Opportunity Comm'n, EEOC Issues Proposed Rule on Application of the ADA to Employer Wellness Programs (Apr. 16, 2015), <https://www.eeoc.gov/eeoc/newsroom/release/4-16-15.cfm>.

terplay of the ACA's incentive provisions and the ADA, GINA and Health Insurance Portability and Accountability Act (HIPAA)'s privacy and anti-discrimination provisions as they relate to wellness programs. Part IV describes the ways in which recent case law has established the legality of potentially intrusive workplace wellness programs under two separate provisions of the ADA, despite its general prohibitions on health-related inquiries in the workplace. It also suggests that the trend towards expansion of wellness programs may subvert the original intent of laws designed to protect employees from misuse of their personal health information. Part V discusses suggestions for practical next steps and additional research.

## I.

### WORKPLACE WELLNESS PROGRAMS ARE BECOMING MORE UBIQUITOUS AND INTRUSIVE

In recent years, the number of employers adopting workplace wellness programs has risen dramatically. This rise is due in part to regulatory incentives for such programs and to the perception that these programs will help stem the increasing costs of health insurance. Wellness programs come in a wide variety of forms and benefit from advances in technology that expand the extent to which they can provide detailed information about employees' health and fitness.

#### *A. Incentivized Wellness Programs Take a Variety of Forms*

Workplace wellness programs are effectively mandated by law. Employers with a sizable work force must offer their full-time employees health benefits. Starting in 2015, all employers with more than 100 full-time equivalent workers were compelled by law to offer some kind of health benefit to full-time employees or pay a penalty.<sup>6</sup> This requirement extended to employers with at least fifty full-time employees in 2016.<sup>7</sup>

A common element of employer-sponsored health benefits is the workplace wellness program. A wellness program, broadly defined, is any program that seeks to promote health or prevent disease.<sup>8</sup> These programs are structured programs offered by employers to improve the health and wellbeing of their employees, and sometimes their employees' families, and take various forms. As a 2013 study commis-

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6. Patient Protection and Affordable Care Act § 1304, 42 U.S.C.A. § 18024 (2016).

7. *Id.*

8. 29 C.F.R. § 2590.702(f) (2016).

sioned for the U.S. Department of Labor explained, “A broad range of benefits are offered under the label ‘workplace wellness,’ from multi-component programs to single interventions, and benefits can be offered by employers directly, through a vendor, group health plans, or a combination of both.”<sup>9</sup>

A simple typology of common wellness program incentives includes the following categories:

- Educational incentives, in which employers offer rewards for finishing things like an online assessment to help employees learn more about their own health and/or health risks. For example, Caterpillar, Inc. charges employees who complete a health risk assessment \$75 less than other employees, and 90% of eligible Caterpillar employees complete the assessment.<sup>10</sup>
- Action incentives, in which employers offer rewards for taking certain actions designed to improve their health. For example, Houston city employees can avoid a \$25 monthly surcharge by taking three actions such as getting a screening, joining a weight loss program, or working with a health coach. Again, 90% of employees take these actions needed to avoid the surcharge.<sup>11</sup>
- Multifaceted incentives, in which employers offer rewards that vary in amount for a wide range of health-related activities. For example, JetBlue Airways gives eligible employees incentives ranging from \$25 for teeth cleaning to \$400 for completing an Ironman triathlon.<sup>12</sup>
- Progress incentives, in which employees are rewarded for reaching certain health benchmarks such as body mass index (BMI) or cholesterol levels.<sup>13</sup> A company might, for example, pay an employee \$100 for losing ten pounds.
- Outcome incentives, which are similar to progress incentives except that employees pay more until they reach the

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9. S. MATTKE ET AL., *WORKPLACE WELLNESS PROGRAMS STUDY: FINAL REPORT* xiii (2013), <https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/workplacewellnessstudyfinal.pdf>.

10. Jen Wieczner, *Your Company Wants to Make You Healthy*, WALL ST. J. (Apr. 8, 2013), <http://www.wsj.com/articles/SB10001424127887323393304578360252284151378>.

11. *Id.*

12. *Id.*

13. *Id.*

benchmarks instead of receiving a discrete reward once they do so.<sup>14</sup>

- Targeted incentives, which tailor incentives to an employee's personal health goals. Designing such a program requires access to the individual employee's health profile. Johnson & Johnson, for example, provides a \$500 discount on insurance premiums for employees who submit a health profile, which is then used to design unique incentives for that employee.<sup>15</sup>

Importantly, employers may attach a substantial carrot and stick to these programs. The ACA specifically allows employers to provide an incentive of up to 30% of the employee-only cost of health insurance coverage for employees who comply with the wellness plan's data-collection provisions and other terms.<sup>16</sup> Employers can offer an even greater incentive, of up to 50% of the coverage cost, to encourage participation in smoking cessation and prevention programs.<sup>17</sup> An employer is taking advantage of this ACA provision when it offers a "bonus" in the form of cash, an Amazon gift card, or a "discount" on an employee's health insurance costs to any employee who completes a health information data intake form. Although federal regulations require that these incentivized wellness plans be "voluntary," the financial penalties associated with noncompliance throws that voluntariness into question. The expansion and regulation of these incentives is described further in Part III of this Article.

Apart from these incentives, an employer may simply refuse to insure employees who do not comply with its wellness plan terms. Under recent case law, an employer may make intrusive health data collection a prerequisite for employer-sponsored health insurance coverage. The employee therefore may choose either to comply with the wellness program's terms or to pay privately for his own health insurance. In *EEOC v. Flambeau*, the EEOC alleged that Flambeau, Inc. violated the ADA by requiring employees to complete a health risk assessment and biometric screening test in order to participate in its health insurance plan.<sup>18</sup> In late 2010, Flambeau introduced a wellness program as part of its corporate-sponsored health insurance plan.<sup>19</sup> The program consisted of a health risk assessment in the form of a

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14. *Id.*

15. *Id.*

16. 42 U.S.C. § 30gg-4(j)(3)(A) (2012).

17. See Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158, 33,159 (June 3, 2013).

18. *Equal Emp't Opportunity Comm'n v. Flambeau, Inc.*, 131 F. Supp. 3d 849 (W.D. Wis. 2015).

19. *Id.* at 852.



questionnaire asking, *inter alia*, about the employees' medical history, and a biometric test similar to a routine physical examination.<sup>20</sup> Flambeau used the data from this program to identify health risks common to its employees to estimate the costs of insurance and set premiums.<sup>21</sup>

In 2011, Flambeau offered employees a \$600 credit for anyone who completed the health risk assessment and biometric test elements of the wellness program.<sup>22</sup> In 2012 and 2013, however, it simply made the program compulsory for anyone enrolling in its health insurance plan.<sup>23</sup> Dale Arnold, a Flambeau employee, participated in the wellness program in 2011, but did not do so in 2012.<sup>24</sup> Flambeau discontinued Arnold's insurance and gave him the option of insuring through COBRA. Arnold refused to do so because of the added expense. The EEOC sued Flambeau on Arnold's behalf, asserting that the wellness plan violated the ADA.<sup>25</sup>

Flambeau responded that its requirements fell within the ADA's safe harbor for the administration of a bona fide insurance plan.<sup>26</sup> The court agreed and granted Flambeau's motion for summary judgment.<sup>27</sup> As a result, employers may make health risk assessments compulsory for employer-sponsored health insurance coverage, although many employees may be unable to afford private health insurance coverage. Part IV of this article examines the impact of case law leading up to and following *Flambeau* and analyzes their likely expansive effect on incentivized workplace wellness programs in future years.

### B. More Employers Are Adopting Wellness Programs

The popularity of workplace wellness programs is growing. According to a 2015 survey by the Society for Human Resource Management (SHRM), 70% of U.S. employers offer a general wellness program. Another 8% planned to offer them in the following twelve months.<sup>28</sup> That is a significant increase from 2008, when 58% of em-

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20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.* at 853.

27. *Id.*

28. SOC'Y FOR HUMAN RES. MGMT., 2015 EMPLOYEE BENEFITS: AN OVERVIEW OF EMPLOYEE BENEFITS OFFERINGS IN THE U.S. (2015), <https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2015-Employee-Benefits.pdf>.

ployers reported having wellness programs.<sup>29</sup> When asked to identify why these programs are so popular, the director of SHRM's survey programs pointed to the ACA.<sup>30</sup> She predicted that wellness programs would continue to grow in popularity, in part for recruiting reasons: "Employers will realize that in order to be competitive, they will need to offer wellness programs. . . . I think we could get close to 100% of organizations having wellness programs."<sup>31</sup>

Another survey found that 81% of large employers, defined as those with 200 or more employees, offer programs that help employees stop smoking, lose weight, or make other behavioral changes.<sup>32</sup> Half of large employers now ask employees or offer them the opportunity to complete a biometric screening, which measures factors such as weight, blood pressure, cholesterol and stress.<sup>33</sup>

Corporate spending on these wellness programs is also rising. A March 2015 survey by the National Business Group on Health predicted that employers would spend an average of almost \$700 per employee on wellness-based incentives in 2015, approximately \$100 more than in 2014 and \$270 more than in 2013.<sup>34</sup> Among larger companies, defined as those with more than 20,000 employees, the per-employee average spend would be \$878 in 2015, up from \$717 in 2014.<sup>35</sup>

### C. *Health Insurance Costs and Data Collection Fuel Wellness Programs' Growth*

Employers embrace wellness programs as a means of reducing health insurance and health care costs.<sup>36</sup> The cost of employer-provided insurance has risen dramatically in the past decade, causing employers to seek new ways of minimizing those costs.<sup>37</sup> The average

29. Vicky Valet, *More Than Two-Thirds of U.S. Employers Currently Offer Wellness Programs, Study Says*, FORBES (July 8, 2015), <http://www.forbes.com/sites/vickyvalet/2015/07/08/more-than-two-thirds-of-u-s-employers-currently-offer-wellness-programs-study-says/#2715e4857a0b557165316c7b>.

30. *Id.*

31. *Id.*

32. *2015 Employer Health Benefits Survey*, HENRY J. KAISER FAM. FOUND. (Sept. 22, 2015) <http://kff.org/report-section/ehbs-2015-summary-of-findings/>.

33. *Id.*

34. Press Release, Nat'l Bus. Grp. on Health, *Companies are Spending More on Corporate Wellness Programs but Employees Are Leaving Millions on the Table* (Mar. 26, 2015), <https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=252>.

35. *Id.*

36. See M. Todd Henderson, *The Nanny Corporation*, 76 U. CHI. L. REV. 1517, 1522, 1542 (2009).

37. *Id.* at 1518.

annual premium for family coverage in 2015 was \$17,545.<sup>38</sup> The cost of those premiums rose 27% between 2010 and 2015, the same rate of growth that they had from 2005 to 2010.<sup>39</sup>

The price employers pay for health coverage will increase for some employers even more dramatically in the coming years. In 2018, a 40% non-deductible excise tax on employer-sponsored health coverage with high-cost benefits will go into effect.<sup>40</sup> This tax, popularly known as the “Cadillac tax,” was intended to function as a disincentive to employers who provide expensive health benefits, which include health insurance. Employers who provide health plans costing more than \$10,200 for an individual or \$27,500 for a family will be liable for 40% of whatever the difference is between the plan costs and those thresholds.<sup>41</sup> Nearly half of large employers responding to a 2015 survey recognize that at least one of their health plans will trigger the Cadillac tax when it is introduced in 2018.<sup>42</sup>

The introduction of the Cadillac tax is driving even more workplaces to adopt wellness programs. Many employers view such programs as a means of lowering the cost of employer-sponsored health plans and mitigating the expected effects of the Cadillac tax. In a June 2015 survey, 70% of responding employers reported that they are expanding wellness programs to delay the impact of the tax.<sup>43</sup> This makes sense in light of the fact that unhealthy claimants increase health care costs overall; indeed, 43% of responding employers described high cost claimants as the number one driver of rising health care costs.<sup>44</sup>

Employers see wellness programs as a means of helping employees improve their health and thereby reduce the cost of their insurance claims. It stands to reason that healthier employees will need less medical care, and presumably help their employers negotiate less expensive premiums, in the future. This is not news. Indeed, in a 2007 poll, 91% of employers responded that they expected to lower their

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38. 2015 *Employer Health Benefits Survey*, *supra* note 32.

39. *Id.*

40. INTERNAL REVENUE SERV., Section 49801—Excise Tax on High Cost Employer-Sponsored Health Coverage Notice 2015-16 (2015), <https://www.irs.gov/pub/irs-drop/n-15-16.pdf>.

41. *Id.*

42. Press Release, Nat’l Bus. Grp. on Health, Health Care Benefits Cost Increases to Hold Steady in 2016, National Business Group on Health Survey Finds (Aug. 12, 2015), <http://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=263>.

43. *Id.*

44. *Id.*

health care costs by encouraging employees to make healthier lifestyle choices.<sup>45</sup>

Another compelling benefit of workplace wellness programs, from a corporate perspective, is their effectiveness in providing data on employee health. Employee health data collection is big business. In January 2016, a consortium of companies including Humana, IBM, Johnson & Johnson, Merck, PepsiCo, and Unilever proposed a plan to disclose their employees' health data to shareholders in their annual reports, 10-K reports, and other corporate disclosures.<sup>46</sup> The collection and disclosure of employee health information is on par with earnings, expenses, and other key economic data that affects a company's profitability and attractiveness to investors.

#### *D. Wellness Programs Use Increasingly Intrusive Technology*

Wellness programs are growing not only in popularity but also in scope and intrusiveness, resulting in an unprecedented ability to gauge data about employees' current and likely future health. The technology available to measure employees' health is more sophisticated than ever, driven by client demands. Employers have an ever-widening range of tools to gauge their employees' health, fitness, and likelihood of developing diseases—all of which affect corporate spending on health insurance.

Employers' use of wearable devices is already common in many workplaces.<sup>47</sup> These devices are commonly used to track employees' physical activity, heart rate, and other physiological markers. The data collected may be analyzed by any number of third party data processors who specialize in performing these analyses for employers and insurers.<sup>48</sup> A primary driver of corporate adoption of wearables is the opportunity to reduce health insurance costs. For example, Appirio, a Bay Area startup, negotiated a \$300,000 discount on its \$5 million insurance costs by agreeing to share employee health data with its

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45. Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359 *NEW ENG. J. MED.* 192, 192 (2008).

46. Daniel Malan et al., *Reporting on Health: A Roadmap for Investors, Companies, and Reporting Platforms*, VITALITY GROUP (Jan. 22, 2016), <http://thevitalityinstitute.org/site/wp-content/uploads/2016/01/Vitality-HealthMetricsReportingRoadmap22Jan2016.pdf>.

47. See generally Elizabeth Brown, *The FitBit Fault Line: Two Proposals to Protect Health and Fitness Data at Work*, *YALE J. HEALTH POL'Y L. & ETHICS* (Winter 2016).

48. Adam Satariano, *Wear This Device So the Boss Knows You're Losing Weight*, *BLOOMBERG* (Aug. 21, 2014, 1:26 PM), <http://www.bloomberg.com/news/articles/2014-08-21/wear-this-device-so-the-boss-knows-you-re-losing-weight>.

insurer and showing that the staff's health was improving.<sup>49</sup> Insurers are working closely with employers to facilitate programs like these. United Health Group, Humana, Cigna, and Highmark have all developed programs that help their employer-clients integrate wearable devices like the Fitbit into the workplace.<sup>50</sup>

Employers may also ask or require their employees to wear smart shirts and sensor-embedded badges to track their activity and productivity.<sup>51</sup> Now that shoes can be built with pressure sensors to detect contact, speed and location, it may only be a matter of time before employers can track employees through their footwear as well.<sup>52</sup> The increasing ubiquity of monitoring employees' physical activity markers makes the regulation of such data collection a growing concern for both employers and employees.<sup>53</sup>

Some workplace wellness programs include genetic testing options as well. Genetic testing has become radically less expensive in the past fifteen years. According to the National Human Genome Research Institute, a division of the National Institutes of Health, it was possible in 2015 to conduct a genomic sequencing test for less than

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49. *Id.*

50. *Id.*

51. Vivian Giang, *Companies Are Putting Sensors on Employees to Track Their Every Move*, BUS. INSIDER (Mar. 14, 2013), <http://www.businessinsider.com/tracking-employees-with-productivity-sensors-2013-3>.

52. Kieran Alger, *The Rise and Fall of the Smart Shoe—And Why They Could Be on the Way Back*, WAREABLE (Aug. 25, 2015), <http://www.wearable.com/running/smart-shoes-875>. Even the furniture in some workplaces may be embedded with sensors that detect the employees' movements. Steelcase, an office furniture manufacturer, recently introduced a Gesture office chair which "monitors workers[]" posture, sitting habits, [and] stress level . . . . As workers sit in Gesture, this data will be displayed on a nearby iPad." Press Release, Steelcase, Steelcase Showcases Office Concept Product Ideas to Help Workers Think Better (June 15, 2015), <http://www.steelcase.com/press-releases/steelcase-showcases-intelligent-office-concept-product-ideas-to-help-workers-think-better/>.

53. Although no federal court has yet recognized a privacy interest in biometric information per se, a remedy may be available under state law. As of this writing, Illinois and Texas are the only two states with biometric privacy laws, although Washington is considering a similar measure. Sam Castic et al., *Biometrics: A Fingerprint for Privacy Compliance, Part I*, ORRICK (Mar. 4, 2016), <http://blogs.orrick.com/trust-anchor/2016/03/04/biometrics-a-fingerprint-for-privacy-compliance-part-i/>. In January 2016, an Illinois court refused to dismiss a claim brought against Shutterfly, in which a user brought a class action lawsuit alleging that Shutterfly violated the state's biometric privacy law by creating "faceprints" or unique identifiers based on the recognition of facial features for each user added to Shutterfly's database. Complaint, *Norberg v. Shutterfly*, 152 F. Supp. 3d 1103 (N.D. Ill. 2015) (No. 1:15-cv-05351). See also Consolidated Class Action Complaint, *Licata v. Facebook*, No. 3:15-cv-03748 (N.D. Cal. 2015).

\$1000, a feat that would have cost \$100 million in 2000.<sup>54</sup> Genetic testing can provide important and increasingly wide-ranging information about an individual's health. It can, for example, detect the presence of biological markers associated with an elevated risk of colon cancer, cystic fibrosis or ovarian cancer, among other diseases.<sup>55</sup>

The results of genetic testing can help suggest a recommended course of action for an employee as well as the likelihood of future health care expense. For example, if an employee's genetic test shows that she has the BRCA1 or BRCA2 gene mutation, which is more common in women of Ashkenazic Jewish descent and associated with an elevated risk of breast cancer, her doctor is likely to recommend that she get more frequent mammograms than women who do not have either mutation.<sup>56</sup> Her doctor may advise her to consider prophylactic surgery to remove as much "at-risk" tissue as possible and prescribe preventative drugs such as tamoxifen to reduce the risk of cancer.<sup>57</sup> The additional mammograms, surgery, and drug treatments may reduce her risk of getting cancer, but also significantly increase the cost of her health care, to her employer's detriment.

Genetic testing will become even more common with the federal government's recent decision to fund the collection of individual genetic information on an unprecedented scale. The government's intent to expand the collection of individualized health information became clear when President Obama announced the launch of the Precision Medicine Initiative in the 2015 State of the Union address.<sup>58</sup> Precision medicine (also called personalized medicine) refers to medical treatment that is tailored to an individual based on that individual's unique genetic information.<sup>59</sup> President Obama requested a \$215 million investment in his 2016 budget for this program, which promised to "pio-

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54. *Cost per Genome*, NAT'L HUM. GENOME RES. INST., [http://www.genome.gov/images/content/cost\\_per\\_genome\\_oct2015.jpg](http://www.genome.gov/images/content/cost_per_genome_oct2015.jpg) (last visited Jan. 20, 2016).

55. Amalia R. Miller & Catherine Tucker, Privacy Protection, Personalized Medicine and Genetic Testing (July 9, 2015) (unpublished manuscript), [https://www.ftc.gov/system/files/documents/public\\_comments/2015/09/00010-97509.pdf](https://www.ftc.gov/system/files/documents/public_comments/2015/09/00010-97509.pdf).

56. *BRCA1 and BRCA2: Cancer Risk and Genetic Testing*, NAT'L CANCER INST., <http://www.cancer.gov/about-cancer/causes-prevention/genetics/brca-fact-sheet> (last visited Jan. 14, 2016).

57. Both prophylactic surgery and the use of tamoxifen have been shown to reduce the risk of cancer in healthy BRCA2 carriers. See, e.g., Miller & Tucker, *supra* note 55, at 6–7.

58. Press Release, The White House, FACT SHEET: President Obama's Precision Medicine Initiative (Jan. 30, 2015), <https://www.whitehouse.gov/the-press-office/2015/01/30/fact-sheet-president-obama-s-precision-medicine-initiative>.

59. *Precision Medicine Initiative*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/scienceresearch/specialtopics/personalizedmedicine/default.htm> (last visited Jan. 14, 2016).

neer a new model of patient-powered research” that will “provide clinicians with new tools, knowledge and therapies to select which treatments will work best for which patients.”<sup>60</sup> More than half of the proposed budget was dedicated to the “engagement” of at least a million participants who would “volunteer” to provide their health data to the database.<sup>61</sup> The program description promised that “privacy will be rigorously protected.”<sup>62</sup> Congress apparently agreed with President Obama about the importance of accelerated genomic database building. In December 2015, Congress voted to provide the National Institutes of Health with \$200 million for the Precision Medicine Initiative.<sup>63</sup> The government’s funding will likely result in more genetic data collection through workplace wellness programs.<sup>64</sup>

## II.

### THE RISKS OF WORKPLACE WELLNESS PROGRAMS MAY OUTWEIGH THE BENEFITS

There are serious and largely unrecognized costs to the expansion of workplace wellness programs, especially where incentives or fines attach to an employees’ choice of whether to participate. While employers have strong financial interests in collecting and analyzing their employees’ health data, employees’ rights and interests may be at stake. One set of harms concerns the potential invasions of employee privacy and the risks of workplace discrimination that workplace wellness programs pose. These potential harms may not be offset by the expected financial benefits of wellness programs, given their limited effectiveness to achieve their stated goals of improving health. Despite these potential harms, lower-income workers may have no other alternative but to forfeit their medical information because of the increased

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60. The White House, *supra* note 58, at 3.

61. *Id.*

62. *Id.*

63. David Nather, *It’s Official: The NIH Budget is Getting an Extra \$2 Billion*, STAT (Dec. 18, 2015) <http://www.statnews.com/2015/12/18/nih-increase-congress-vote/>.

64. The FDA has created a collective research and development portal to bring together various approaches to the kind of genetic code processing that enables precision medicine, and held a public workshop to discuss its proposed regulatory approach in February 2015. *Optimizing FDA’s Regulatory Oversight of Next Generation Sequencing Diagnostic Tests—Preliminary Discussion Paper*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/downloads/MedicalDevices/NewsEvents/WorkshopsConferences/UCM427869.pdf> (last visited Jan. 14, 2016); *Public Workshop—Optimizing FDA’s Regulatory Oversight of Next Generation Sequencing Diagnostic Tests Public Workshop, February 20, 2015*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/MedicalDevices/NewsEvents/WorkshopsConferences/ucm427296.htm> (last visited Jan. 14, 2016).

use of substantial financial incentives. For these reasons, the social injustice of workplace wellness programs may well outweigh any financial benefits employers can reasonably expect.

### A. *The Social Harms of Incentive-Based Wellness Programs*

While one of Congress's purposes in enacting HIPAA was to protect the privacy of personal health information, the use of third parties, who are not necessarily "covered entities" under HIPAA's reach, undermines the privacy protections HIPAA affords in practice. In addition, the risks of discrimination that stem from incentivized health data collection are not entirely mitigated by the anti-discrimination provisions of existing federal law.

#### 1. *HIPAA Offers Limited Privacy Protections for Wellness Program Data*

HIPAA was designed to protect the confidentiality of patients' health information.<sup>65</sup> HIPAA regulates the administration of workplace wellness programs in two ways. First, it affects the availability of wellness programs within a workplace. Its non-discrimination provisions ensure that any wellness program must be available to all similarly situated individuals. Employers cannot offer different programs to certain employees based on their ability or health status except as specifically allowed by federal law.<sup>66</sup>

HIPAA also protects the confidentiality of some personal health information that employees may disclose in connection with a wellness program.<sup>67</sup> HIPAA's protections are limited in important ways, however, when it comes to workplace wellness programs. For example, HIPAA may not protect the kind of health and fitness data that wearable technology or fitness apps might collect.<sup>68</sup>

According to the U.S. Department of Health and Human Services, the HIPAA Privacy Rule "establishes . . . a set of national standards for the protection of certain health information. . . . The Privacy Rule standards address the use and disclosure of individuals' health

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65. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 221, 110 Stat. 1936, 2009 (1996).

66. EMP. BENEFITS SEC. ADMIN., U.S. DEP'T OF LABOR, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART V AND MENTAL HEALTH PARITY IMPLEMENTATION (2010), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-v.pdf>.

67. See generally 45 C.F.R. § 164.500-534 (2015).

68. See Timothy S. Hall, *The Quantified Self Movement: Legal Challenges and Benefits of Personal Biometric Data Tracking*, 7 AKRON INTELL. PROP. J. 27, 29-30 (2014).



information . . . by organizations subject to the Privacy Rule—called ‘covered entities,’ as well as standards for individuals’ privacy rights to understand and control how their health information is used.”<sup>69</sup> The “covered entities” include health care providers, health plans (including insurers and HMOs), and health care “clearinghouses” that translate health information from one format to another.<sup>70</sup> Certain HIPAA laws also apply to the “business associates” that covered entities hire to help them carry out health care functions.<sup>71</sup> HIPAA only restricts what covered entities and their business associates can do. Other entities and individuals are not so restricted. If an employee’s health information is passed to a third party that is not a “health care provider, health plan, employer, or health care clearinghouse,” nor an agent for any such entity, the data fall outside of the statutory HIPAA protections. Wellness program managers may qualify as such third parties and therefore may not be bound by HIPAA.

Even if HIPAA offered relevant protection, it does not offer a private right of action.<sup>72</sup> The Clinton Administration supported the inclusion of a private right of action for patients under HIPAA, but Congress did not act on these recommendations.<sup>73</sup> Only the Office for Civil Rights of the Department of Health and Human Services may investigate and impose civil and criminal penalties against a health care provider for violations of HIPAA.<sup>74</sup>

## 2. *The ADA Cannot Protect Employees from All Misuse of Health Data*

Like HIPAA, the ADA does not fully protect employees from discrimination based on the kind of data they are likely to provide through a workplace wellness program. While the ADA may protect employees from discrimination based on actual or perceived disability, it does little to shield them from discrimination based on many kinds

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69. U.S. DEP’T OF HEALTH & HUMAN SERV., SUMMARY OF THE HIPAA PRIVACY RULE 1 (2003), <https://www.hhs.gov/sites/default/files/privacysummary.pdf>.

70. 45 C.F.R. §160.103 (2014).

71. U.S. DEP’T OF HEALTH & HUMAN SERV., BUSINESS ASSOCIATES 1 (2003).

72. 42 U.S.C. §§ 1320d-5 to -6 (2012).

73. See Joshua D.W. Collins, *Toothless HIPAA: Searching for a Private Right of Action to Remedy Privacy Rule Violations*, 60 VAND. L. REV. 199, 222–23 (2007).

74. See 65 Fed. Reg. 82462-01 (Dec. 28, 2000); see also *Acara v. Banks*, 470 F.3d 569, 571 (5th Cir. 2006) (holding no private cause of action for disclosure of PHI during a deposition); *Univ. of Colo. Hosp. v. Denver Publ’g Co.*, 340 F. Supp. 2d 1142, 1145 (D. Colo. 2004) (finding no HIPAA private cause of action because the statute created enforcement means for aggrieved persons); *O’Donnell v. Blue Cross Blue Shield of Wyo.*, 173 F. Supp. 2d 1176, 1179–80 (D. Wyo. 2001) (holding that no express or implied private cause of action exists in HIPAA).

of data collected through wellness programs. For example, such programs may collect information revealing an employee's high cholesterol, relative physical inactivity, sleeplessness, or high levels of stress. This kind of information can be elicited through questionnaires and wearable sensors. It is easy to imagine a scenario in which an employer uses the health data it collects to make employment decisions, including hiring and promotion.<sup>75</sup> Evaluating an employee for a promotion based on the likelihood that the employee will develop an expensive health condition later in life, based on her wellness program data, would not invoke disability law because no specific disability is invoked or perceived.<sup>76</sup> While those conditions may correlate with an increased risk of disability, none of them is in itself a current or perceived disability. An employer may discriminate against employees individually or as a group based on this kind of information without violating the ADA.

Federal anti-discrimination laws, however, cannot protect employees against decisions made on these bases or any basis other than, and not necessarily correlated with, a protected class.

### 3. *Weight-Based Incentives Stigmatize Overweight Employees*

Another social cost is the stigmatization of heavier employees that wellness programs facilitate by collecting detailed information about weight for potential employer use. To the extent that employers make adverse decisions based on employees and applicants' health or lifestyle, unhindered by federal law, some scholars have suggested that employers are engaging in a form of discrimination called "healthism."<sup>77</sup> When employers favor hiring healthier workers and reject less healthy applicants (or those perceived as being less healthy),

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75. See, e.g., Scott R. Peppet, *Regulating the Internet of Things: First Steps Towards Managing Discrimination, Privacy, Security and Consent*, 93 TEX. L. REV. 85, 119 (2014) (citations omitted) ("Impulsivity and the inability to delay gratification—both of which might be inferred from one's exercise habits—correlate with alcohol and drug abuse, disordered eating behavior, cigarette smoking, higher credit-card debt, and lower credit scores. Lack of sleep—which a Fitbit tracks—has been linked to poor psychological well-being, health problems, poor cognitive performance, and negative emotions such as anger, depression, sadness, and fear. Such information could tip the scales for or against [a job candidate.]"); see also Dennis D. Hirsch, *That's Unfair! Or is it? Big Data, Discrimination and the FTC's Unfairness Authority*, 103 KY. L.J. 345, 350–52 (2015) (describing potential discrimination resulting from use of health-related Big Data); Jessica L. Roberts, *Protecting Privacy to Prevent Discrimination*, 56 WM. & MARY L. REV. 2097, 2122 (2015) (noting potential for discrimination when access opens to private information).

76. Peppet, *supra* note 75, at 125–26.

77. See generally Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571 (2014).

one consequence is that those less healthy people will have to rely on exchanges instead of employers for their health insurance.<sup>78</sup> The federal government will then have to pay more to subsidize the cost of insurance for those individuals without employer-subsidized care.<sup>79</sup>

Using health as a factor in employment decisions may have unintended adverse effects on the unemployed or less employed. First, it makes it more difficult for those populations to get access to preventative care and to make healthy choices by limiting their access to both employer-provided benefits such as health insurance and the wages needed to buy healthier food.<sup>80</sup> Second, it tends to deny those populations the opportunity to engage in the workplace wellness programs designed to improve health.<sup>81</sup> Favoring fitter employees, in Jessica Roberts's words, "could—perhaps counter-intuitively—generate a healthier *workforce* but a less healthy *total population*."<sup>82</sup>

To the extent wellness programs focus on weight reduction overall rather than lowered health costs, they worsen the employment obstacles that overweight workers must already deal with. As other scholars have explained, overweight workers face stigma that may affect whether and how often they are hired or promoted.<sup>83</sup> However, the effect of this stigma is far from straightforward. Various studies have found that overweight people are less likely to be hired by prospective employers and more likely to suffer the effects of weight stigma on the job.<sup>84</sup> In 2011, however, another poll found that more than 80% of U.S. residents believed that employers should not be able to refuse to hire applicants because the applicants are overweight or smokers.<sup>85</sup> This inconsistency has played out in workplaces as well. In

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78. *Id.* at 625–26.

79. Wellness programs' focus on exercise as a form of weight control is controversial in other ways as well. They have been criticized as "lifestyle discrimination," in that they reward participation in activities that are more easily accessed by relatively affluent people. *See, e.g.,* Mello & Rosenthal, *supra* note 45. Others note that caregivers, most often women, have less time to exercise because of their other obligations outside of paid work. *See, e.g.,* Matthew A. Stults-Kolehmainen & Rajita Sinha, *The Effects of Stress on Physical Activity and Exercise*, 44 *SPORTS MED.* 1, 81–121 (2014).

80. Roberts, *supra* note 75, at 626.

81. *Id.*

82. *Id.* at 625.

83. *Id.* at 585–86.

84. Rebecca M. Puhl & Chelsea A. Heuer, *The Stigma of Obesity: A Review and Update*, *OBESITY* (Jan. 22, 2009), <http://www.uconnruddcenter.org/resources/upload/docs/what/bias/WeightBiasStudy.pdf>.

85. Elizabeth Mendes, *Americans Don't Want Biases in Hiring Smokers, the Overweight*, *GALLUP* (July 22, 2011), <http://www.gallup.com/poll/148619/americans-don-biases-hiring-smokersoverweight.aspx>.

2012, a Texas hospital adopted a ban on hiring obese workers, in part because of concerns about its business image. Its policy explained that employees' appearance "should fit with a representational image or specific mental projection of the job of a healthcare professional."<sup>86</sup> The hospital later reversed that policy.<sup>87</sup>

Workplace discrimination against obese employees was not always remediable through Title VII of the Civil Rights Act or the ADA.<sup>88</sup> When the EEOC first issued its Interpretive Guidance on the ADA, it noted that "except in rare circumstances, obesity is not considered a disabling impairment."<sup>89</sup> After the ADA was amended in 2008, the EEOC removed that language from its revised Interpretive Guidance.<sup>90</sup> Some viewed the amended law as a sign that obesity alone might receive more legal protection than it had before 2008. One scholar expressed hope that "with the passage of the [Americans with Disabilities Act Amendments Act (ADAAA)], certain claims of obesity-as-a-disability will likely be successful in the future."<sup>91</sup>

For several years, courts moved toward recognizing obesity as a disability in itself under the ADA. In 2010, the EEOC filed a complaint seeking protection under the ADA for a woman who claimed she was fired because of her severe obesity.<sup>92</sup> The court agreed with the EEOC that severe obesity could be a disability as the ADA defines it, and the parties settled in April 2012.<sup>93</sup> In July 2012, the EEOC announced the settlement of a discrimination case brought against a BAE Systems subsidiary for its failure to reasonably accommodate a

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86. Emily Ramshaw, *Victoria Hospital Won't Hire Very Obese Workers*, TEX. TRIB. (Mar. 26, 2012), <https://www.texastribune.org/2012/03/26/victoria-hospital-wont-hire-very-obese-workers/>.

87. See Roberts, *supra* note 75, at 574.

88. *Id.* at 595; see also 29 C.F.R. § 1630.2(j)(3)(iii) (2016) (stating that certain impairments "substantially limit . . . major life activities").

89. Interpretive Guidance on Title I of the Americans with Disabilities Act, 56 Fed. Reg. 35,741 (July 26, 1991).

90. Jennifer B. Shinall, *What Happens When the Definition of Disability Changes? The Case of Obesity*, 5 IZA J. LAB. ECON. 2 (2016).

91. Abigail Kozel, *Large and in Charge of Their Employment Discrimination Destiny: Whether Obese Americans Now Qualify as Disabled Under the Americans with Disability Act Amendments Act of 2008*, 31 HAMLINE J. PUB. L. & POL'Y 273, 327 (2009).

92. Press Release, U.S. Equal Emp. Opportunity Comm'n, EEOC Sues Resources for Human Development, Inc. for Disability Discrimination (Sept. 30, 2010), <http://www.eeoc.gov/eeoc/newsroom/release/9-30-10u.cfm>.

93. Press Release, U.S. Equal Emp. Opportunity Comm'n, Resources for Human Development Settles EEOC Disability Suit for \$125,000 (Apr. 10, 2012), <http://www.eeoc.gov/eeoc/newsroom/release/4-10-12a.cfm>.

morbidly obese employee.<sup>94</sup> In April 2014, a federal judge ruled that an employee's severe obesity could provide the basis for an anti-discrimination case under the ADA.<sup>95</sup> Institutional acceptance of obesity as a protectable and possibly treatable condition has expanded in other ways at the same time. In 2013, the American Medical Association officially recognized obesity as a disease.<sup>96</sup> In light of these developments, a major law firm advised employers to "treat morbid or severe obesity as a 'disability,' irrespective of the existence of an underlying physiological disorder."<sup>97</sup>

In 2016, however, an important ruling signaled a limit to the ADA's protection of obesity. In *Morriss v. BNSF Railway Company*, the United States Court of Appeals for the Eighth Circuit held that obesity not caused by an underlying physiological disorder is not a disability under the ADA.<sup>98</sup> Plaintiff Melvin Morriss had applied for a machinist position and got the job, contingent on a satisfactory health review, but when his potential employer confirmed that he was 5'10" tall and weighed approximately 280 pounds, it revoked the offer.<sup>99</sup> The appellate court interpreted the EEOC's regulations defining "physical impairment" under the ADA to exclude conditions that are not the result of a physiological disorder or condition.<sup>100</sup> As a result, the employer's revocation of Mr. Melvin's job offer due to his weight was not employment discrimination prohibited by the ADA.<sup>101</sup>

The *Morriss* ruling underscores the employment risks that overweight people face in disclosing their health information to employers through wellness programs, and the lack of reliable protection afforded to them by the ADA in taking that risk.

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94. Press Release, U.S. Equal Emp. Opportunity Comm'n, BAE Systems Subsidiary to Pay \$55,000 to Settle EEOC Disability Discrimination Suit (July 24, 2012), <http://www.eeoc.gov/eeoc/newsroom/release/7-24-12c.cfm>.

95. *Whittaker v. Am.'s Car-Mart, Inc.*, No. 1:13-CV-108 SNLJ (E.D. Mo. Apr. 24, 2014).

96. Andrew Pollack, *AMA Recognizes Obesity as a Disease*, N.Y. TIMES (June 18, 2013) [http://www.nytimes.com/2013/06/19/business/ama-recognizes-obesity-as-a-disease.html?\\_r=0](http://www.nytimes.com/2013/06/19/business/ama-recognizes-obesity-as-a-disease.html?_r=0).

97. David Katz, *Another Judge Finds that Obesity May Be a "Disability" Under the ADA*, NAT'L L. REV. (May 6, 2014), <http://www.natlawreview.com/article/another-judge-finds-obesity-may-be-disability-under-ada-americans-disabilities-act#sthash.Zr8gla0Y.dpuf>.

98. *Morriss v. BNSF Ry. Co.*, 817 F.3d 1104 (8th Cir. 2016).

99. *Id.* at 1106.

100. *Id.* at 1107.

101. *Id.*

#### 4. *The Cost of Privacy May Be Too High for Many Employees*

Perhaps the greatest social cost of workplace wellness program is that they put a price on employees' health privacy that many employees may be unable to pay. Any significant cost is likely to render a wellness program involuntary. As Alexander Hamilton wrote in the *Federalist Papers*, "In the general course of human nature, a power over a man's subsistence amounts to a power over his will."<sup>102</sup>

As explained in more detail in Part III, federal law gives employers substantial leeway in persuading employees to complete health questionnaires, undergo genetic testing, and complete other common elements of workplace wellness programs. They may do so by providing a financial incentive for completing a questionnaire, such as a gift card or a discount on insurance costs. The value of that incentive can be up to 30% of the employee-only cost of the health insurance.<sup>103</sup> If, for example, an employee's health insurance costs \$15,000, his employer may use an incentive of up to \$4500 to persuade that employee to participate in the wellness program. The cost of health insurance, however, does not rise with an employee's salary, nor, therefore, does the permissible incentive. Someone who earns \$80,000 per year may be less able to afford a \$4500 penalty, or to forgo a \$4500 bonus, than someone who earns \$280,000.

Employers may also condition employer-sponsored health care coverage on participation in the wellness program, a practice condoned in *EEOC v. Flambeau*. Employees who would rather not give up the personal health data that many programs collect have the "choice" to opt out and insure themselves and their families privately. Of course, employer-sponsored health care coverage is not a right, but a valuable benefit that many families rely on. Restricting that benefit to those who are willing to sacrifice their personal health privacy is arguably unjust.

#### B. *The Inefficiencies of Incentive-Based Wellness Programs*

The potential social harms of workplace wellness programs undercut their overall benefit as a corporate function. Beyond these risks to employees, however, is the risk to employers that many of these programs simply do not work as advertised. Wearable devices that collect health information as part of workplace wellness programs, for example, are susceptible to user hacking and have been accused of

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102. THE FEDERALIST No. 79 (Alexander Hamilton).

103. 42 U.S.C. § 300gg-4(j)(3)(A) (2012).

being inherently inaccurate. Several other flaws in the system of wellness programs strengthen the argument against their use.

*1. Wellness Programs May Not Help Employees Become Healthier*

One of the strongest arguments against incentive-based workplace wellness programs is that they may be ineffective in achieving their stated purpose. The assumption that paying people encourages them to lose weight may be flawed. A workplace weight loss study conducted from 2013 to 2015 compared weight loss rates among four groups: (1) a control group given no incentive to lose weight, (2) a group given a health insurance premium adjustment incentive, to take effect the following year, (3) a group given a health insurance premium adjustment incentive effective immediately, and (4) a daily lottery incentive.<sup>104</sup> The incentives in all three of the incentive groups had the same value of \$550.<sup>105</sup> The study found no statistically significant differences among any of the groups, and concluded that the incentive-based weight loss programs tested had no appreciable effect.<sup>106</sup>

In fact, the federal agencies charged with analyzing the final rule on Incentives for Nondiscriminatory Wellness Programs admitted that the evidence was, at best, mixed as to the effectiveness of such programs.<sup>107</sup> Writing in 2013, the agencies noted that “currently, insufficient broad-based evidence makes it difficult to definitively assess the impact of workplace wellness programs on health outcomes and cost.”<sup>108</sup> They appeared to take employers’ word for this unproven effectiveness, continuing that “overall, employers largely report that workplace wellness programs in general (participatory wellness programs and health-contingent wellness programs) are delivering on their intended objectives of improving health and reducing costs.”<sup>109</sup> The employers must know best, reasoned the authors, using “economic logic” to “conclude that employers will create or expand their wellness program and provide reasonable alternatives only if the expected benefits exceed the expected costs.”<sup>110</sup>

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104. Patel et al., *Premium-Based Financial Incentives Did Not Promote Workplace Weight Loss in a 2013–15 Study*, 35 HEALTH AFF. 171 (2016).

105. *Id.*

106. *Id.*

107. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,157, 33,165 (June 3, 2013).

108. *Id.* at 33,169.

109. *Id.*

110. *Id.*

Using economic logic to assess the likelihood of potentially discriminatory action raises logical issues of its own. Many employers do not use economic logic to justify their wellness programs. The preamble to the final rule on Incentives for Nondiscriminatory Wellness Programs noted that more than half of employers surveyed in 2010 reported that they did not know their programs' return on investment. Additionally, in a 2012 survey, "only about half of employers with wellness programs stated that they had formally evaluated program impact, and only two percent reported actual cost savings."<sup>111</sup>

## 2. *Wearable Sensor Devices Can Be Easily Manipulated*

Another downside of workplace wellness programs is their frequent reliance on devices that provide unreliable data because they are highly susceptible to user manipulation. As workplace wellness programs develop, many of them employ wearable fitness devices such as the Fitbit and similar products. Fitbits, which come in a range of models and styles, are wearable personal devices that can track a user's heart rate, steps taken, location, and other data relating to activity and health.

Corporate spending on Fitbits for employee use has grown significantly over the past five years. More workplaces are either requiring or requesting that employees wear Fitbits as an element of their workplace wellness programs. For example, BP offers a program by which employees can cut \$1200 from their annual insurance bills in exchange for wearing a Fitbit and logging a sufficient amount of physical activity.<sup>112</sup> When BP introduced this free Fitbit program in 2013, 14,000 employees, 6000 spouses, and 4000 retirees signed up.<sup>113</sup> Like other employers, BP faces rising health care costs and is looking for ways to reduce them. Although some may question the genuineness of an employer-sponsored discount on health insurance rates, insurers are starting to offer similar discounts directly. For example, John Hancock Insurance offered customers up to a 15% discount on their insurance rates in exchange for healthful activity as measured by the Fitbits these customers agreed to wear.<sup>114</sup>

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111. *Id.* at 33,171.

112. Satariano, *supra* note 48.

113. Parmy Olson & Aaron Tilley, *The Quantified Other: Nest and Fitbit Chase a Lucrative Side Business*, FORBES (Apr. 17, 2014), <http://www.forbes.com/sites/parmy-olson/2014/04/17/the-quantified-other-nest-and-fitbit-chase-a-lucrative-side-business/#1e9052cc5403>.

114. Tara S. Bernard, *Giving Out Private Data for Discount in Insurance*, N.Y. TIMES (Apr. 8, 2015), <https://www.nytimes.com/2015/04/08/your-money/giving-out-private-data-for-discount-in-insurance.html>.



Insurers are working closely with employers to facilitate programs like these. United Health Group, Humana, Cigna, and Highmark have all developed programs that help their employer-clients integrate wearable devices into the workplace.<sup>115</sup> In a common scenario, in contrast, the employer would provide some incentive for reaching a certain goal that the device can measure, such as an average number of steps taken per week.

That may not work as the employer intends. As more employees are realizing, there are ways to make the Fitbit reflect physical activity that the employee is not personally engaged in. One way is to hire someone else to wear the Fitbit for you. Another kind of Fitbit manipulation was shown on an episode of the *Big Bang Theory* entitled “The Perspiration Implementation,” which aired in October 2015.<sup>116</sup> In the first scene, a character invents a robot designed to add mileage to the Fitbit his wife wants him to wear. In the last scene, the character’s wife asks why his Fitbit says that he ran 174 miles the previous day.<sup>117</sup> Although creating a robot for this purpose may be infeasible for many employees, an alternative hack would be to put it on your dog.<sup>118</sup> According to Fitbit, 47% of Fitbit users surveyed say that they live with at least one dog.<sup>119</sup>

### 3. *Wearable Sensor Devices May Be Inherently Inaccurate*

Another potential concern is the extent to which wearable devices used in workplace wellness programs provide accurate data even without user manipulation. In January 2016, consumers from California, Colorado, and Wisconsin filed a national class action lawsuit against Fitbit alleging that the heart rate tracking technology used in some of its fitness watches is “wildly inaccurate” and “consistently mis-record[s] heart rates by a very significant margin.”<sup>120</sup> Eight months earlier, a California consumer had filed a class action complaint against Fitbit alleging that the sleep-tracking function of certain Fitbit devices

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115. *Id.*

116. *The Perspiration Implementation*, BIG BANG THEORY WIKI, [http://bigbangtheory.wikia.com/wiki/The\\_Perspiration\\_Implementation](http://bigbangtheory.wikia.com/wiki/The_Perspiration_Implementation) (last visited Feb. 20, 2016).

117. *Id.*

118. *Fitbit for Business That’s a Bit of a Surprise (Forum)*, SPICEWORKS (Sept. 4, 2015), <https://community.spiceworks.com/topic/post/4992163>.

119. *The Positive Impact Dogs Have on Your Fitness (Infographic)*, FITBIT (Jan. 22, 2015), <https://blog.fitbit.com/dog-gone-data/>.

120. Lief Cabraser, *Consumers File Nationwide Fraud Class Action Against Fitbit, Inc.*, LIEFF CABRASER HEIMANN & BERNSTEIN (Jan. 5, 2016), <http://www.lieffcabraser.com/blog/2016/01/consumers-file-nationwide-fraud-class-action-against-fitbit-inc.shtml>.

does not work as advertised.<sup>121</sup> The plaintiff complained that these sleep-tracking devices “consistently misidentify sleep” by using relatively inaccurate technology: “The Fitbit sleep-tracking function simply does not and cannot inform the user how well they slept with any accuracy whatsoever.”<sup>122</sup>

Wearable devices are not monitored for accuracy by the Food and Drug Administration (FDA). Many of the health and fitness apps and devices that might transmit data of interest to employers fall into the FDA’s “general wellness products” category.<sup>123</sup> One example would be “a portable product that claims to monitor the pulse rate of users during exercise and hiking.”<sup>124</sup> The FDA classifies this as a “general wellness product” because “[t]his claim relates only to exercise and hiking and does not refer to a disease or medical condition” and because “the technology for monitoring poses a low risk to the user’s safety.”<sup>125</sup> The FDA suggests that it has no plans to regulate these “general wellness products.”<sup>126</sup>

Indeed, Fitbit itself does not claim that its products should be held to the same standards as regulated medical devices. In a statement responding to the heart rate monitor class action lawsuit, Fitbit noted that its “trackers are designed to provide meaningful data to our users to help them reach their health and fitness goals” but “are not intended to be scientific or medical devices.”<sup>127</sup>

#### 4. *Sensor Fusion Facilitates the Re-Identification of Anonymized Data*

Another risk facing participants in some workplace wellness programs stems from the re-identification of supposedly anonymized health data.<sup>128</sup> Data collected through wellness programs are usually

121. Complaint, *Brickman v. Fitbit, Inc.*, No. 4:15-cv-2077 (N.D. Cal. 2015).

122. *Id.* ¶ 25.

123. Thomas Sullivan, *FDA Device Guidance: General Wellness Policy for Low Risk Devices*, POL’Y & MED. (Jan. 29, 2015), <http://www.policymed.com/2015/01/fda-device-guidance-general-wellness-policy-for-low-risk-devices.html>.

124. U.S. FOOD & DRUG ADMIN., GENERAL WELLNESS: POLICY FOR LOW RISK DEVICES 7 (2016).

125. *Id.*

126. Sullivan, *supra* note 123.

127. Marisa Kendall, *Lieff Cabraser Team Sues Fitbit over Heart Rate Readings*, RECORDER (Jan. 5, 2016), <http://www.therecorder.com/id=1202746342738/Lieff-Cabraser-Team-Sues-Fitbit-Over-Heart-Rate-Readings?slreturn=20170120173440>.

128. See, e.g., Tatiana Komarova, Denis Nekipelov, & Evgeny Yakovlev, *Estimation of Treatment Effects from Combined Data: Identification Versus Data Security*, in *ECONOMIC ANALYSIS OF THE DIGITAL ECONOMY* 279 (Avi Goldfarb et al. eds., 2015), <http://www.cpc.unc.edu/projects/rhms-hse/publications/2247>.

aggregated to some extent before being passed on to employers, in order to avoid the HIPAA prohibition on conveying individually identifiable health information. The aggregation and presumed anonymization of data influenced the decision in *Seff v. Broward County*, one of the few cases to review the permissibility of wellness programs under the insurance safe harbor provision of the ADA.<sup>129</sup> That provision notes that the ADA's non-discrimination protections do not apply to a "bona fide benefit plan" that is "based on underwriting risks [or] classifying risks."<sup>130</sup> The *Seff* court noted that the wellness program at issue "renders aggregate data to the [defendant] County that it may analyze when developing future benefit plans. . . . Though it is not classifying risk on an individual basis, it is underwriting and classifying risks on a macroscopic level so it may form economically sound benefit plans for the future."<sup>131</sup>

The security of aggregating data, however, has largely been disproven. Employers can now re-engineer or re-identify data to link it back to an individual person.<sup>132</sup> This process, also known as "sensor fusion," is now commonly used to collate and synthesize data about a single individual from multiple sources.<sup>133</sup> When HIPAA was passed in 1996, it was more difficult to re-identify data that had been unlinked to an individual user, but recent technological developments have made it easier.<sup>134</sup> The expansion of data available about each of us from a range of sources, including where we take our phones and what websites we visit, facilitates the re-identification process.<sup>135</sup> Whether HIPAA or any other federal law protects such re-identified data has yet to be determined in court.

An additional security risk concerns data leakage. Employers who collect health and fitness data are susceptible to security breaches, possibly leading to the unauthorized distribution of that data.

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129. *Seff v. Broward County*, 778 F. Supp. 2d 1370, 1374 (S.D. Fla. 2011).

130. 42 U.S.C. § 12112(d)(4)(A) (2016).

131. *Seff*, 778 F. Supp. 2d at 1374.

132. N. Nina Zivanovic, *Medical Information as a Hot Commodity: The Need for Stronger Protection of Patient Health Information*, 19 INTELL. PROP. L. BULL. 183 (2015); see generally *Re-Identification*, ELECTRONIC INFO. PRIVACY CTR., <https://epic.org/privacy/reidentification/> (last visited Feb. 20, 2016).

133. See, e.g., T. Phan et al., *Sensor Fusion of Physical and Social Data Using Web SocialSense on Smartphone Mobile Browsers*, 11TH ANN. IEEE CONSUMER COMM. & NETWORKING CONF. (2014).

134. Paul Ohm, *Broken Promises of Privacy: Responding to the Surprising Failure of Anonymization*, 57 UCLA L. REV. 1701, 1706 (2010).

135. Paul M. Schwartz & Daniel J. Solove, *The PII Problem: Privacy and a New Concept of Personally Identifiable Information*, 86 N.Y.U. L. REV. 1814, 1841 (2011).

Such security breaches are on the rise. According to one survey, there were over 300,000 reported cases of medical identity theft in 2013, a 19% increase over the previous year.<sup>136</sup>

### III.

#### FEDERAL REGULATIONS PROMOTE THE USE OF INCENTIVES IN WELLNESS PROGRAMS

Whether an employee chooses to participate in a workplace wellness program may depend on the relative costs of agreeing and refusing to do so. In recent years, regulatory guidance has encouraged employers to adopt greater financial incentives to persuade employees to participate in these wellness programs, while maintaining the legal fiction that such programs are “voluntary.”

Workplace wellness programs are subject to a complex web of federal regulations, including HIPAA, the ACA, the ADA and GINA. One way to categorize the laws affecting workplace wellness programs is to divide the major regulations into groups according to what they do. For example, in a 2014 article, E. Pierce Blue, then an Attorney Advisor to the Commissioner of the EEOC, distinguished the ACA and HIPAA from GINA and the ADA by noting that the former two dictate the scope of permissible workplace incentives while the latter two govern how employers can collect medical information from their employees.<sup>137</sup>

#### A. *The ACA Expanded Support for Incentivized Workplace Wellness Programs*

The ACA<sup>138</sup> expanded the scope of permissible employee wellness program incentives, including financial penalties for employees who don't comply with them. A major goal of the ACA was to encourage disease prevention, according to former Secretary of Health and Human Services Kathleen Sebelius and Dr. Howard Koh. Writing in the *New England Journal of Medicine*, they noted that “[t]oo many people in our country are not reaching their full potential for health

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136. PONEMON INST., 2013 SURVEY ON MEDICAL IDENTITY THEFT 2 (Sept. 2013), <https://clearwatercompliance.com/wp-content/uploads/2013/10/2013-Medical-Identity-Theft-Report-FINAL.pdf>.

137. E. Pierce Blue, *Wellness Programs, the ADA and GINA: Framing the Conflict*, 31 HOFSTRA LAB. & EMP. L.J. 367 (2014).

138. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reform Act of 2010, Pub. L. No. 111-152, 124 Stat. 1209 (2010) (codified as amended in scattered sections of 42 U.S.C.).

because of preventable conditions.”<sup>139</sup> They observed that the “Affordable Care Act responds to this need with a vibrant emphasis on disease prevention.”<sup>140</sup> They concluded that “[t]he Act breaks new ground [in order to] prevent disease and promote health and wellness.” As Jennifer Bard characterizes it, “ACA promotes prevention by supporting a wide variety of programs that focus on the public health model of identifying and minimizing risk.”<sup>141</sup>

The ACA encourages wellness programs in two ways. First, it provides grants to help employers develop wellness programs.<sup>142</sup> The Prevention and Public Health Fund designates a funding stream for a variety of preventive health programs including workplace wellness programs.

Second, it increases the incentives employers may offer for participation in workplace wellness programs. Before the ACA was passed, the Department of Labor set a cap for incentives at 20% of the total cost of coverage under the insurance plan.<sup>143</sup> The ACA increased and codified the cap to allow employers to discount the cost of health insurance for wellness program participants who meet certain goals by up to 30%.<sup>144</sup> It also gave the Secretaries of Health and Human Services, Treasury, and Labor the discretion to increase the discount to 50% of the total cost of coverage.<sup>145</sup>

In the final regulations, the Secretaries used this discretion to increase the maximum incentive for smoking cessation and prevention programs to 50% of the total coverage cost.<sup>146</sup> The maximum incentive for all other wellness programs remained at 30%.<sup>147</sup> Although federal regulations require that these wellness plans be voluntary, the financial penalties associated with noncompliance throws that voluntariness into question.

Federal law establishes two types of workplace wellness programs. In 2006, the Departments of Labor, Health and Human Ser-

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139. Howard K. Koh & Kathleen G. Sebelius, *Promoting Prevention Through the Affordable Care Act*, 363 *NEW ENG. J. MED.* 1296 (2010).

140. *Id.*

141. Jennifer Bard, *When Public Health and Genetic Privacy Collide: Positive and Normative Theories Explaining How ACA's Expansion of Corporate Wellness Programs Conflicts with GINA's Privacy Rules*, 39 *J.L. MED. & ETHICS* 469, 471 (2011).

142. Patient Protection and Affordable Care Act § 2801(c)(1).

143. Nondiscrimination & Wellness Programs in Health Coverage in the Group Market, 71 *Fed. Reg.* 75,014, 75,018 (Dec. 13, 2006).

144. 42 U.S.C. § 300gg-4(j)(3)(A) (2012).

145. Patient Protection and Affordable Care Act § 2705(j)(3)(A).

146. *See* Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 *Fed. Reg.* 33,157, 33,159 (June 3, 2013).

147. *Id.*

vices, and the Treasury published regulations that divided workplace wellness programs into two general categories: participatory wellness programs and health-contingent wellness programs.<sup>148</sup> Participatory wellness programs provide opportunities for employees to take part without evaluating the consequences of their participation.<sup>149</sup> A workplace wellness program that subsidizes the cost of a fitness center membership, for example, would qualify as a participatory program. Health-contingent programs condition some aspect of the program on the completion or accomplishment of at least one task, and may or may not provide an incentive in connection with the task.

Health-contingent wellness programs are subject to five requirements.<sup>150</sup> One requirement is that the incentive must not exceed 30% of the total cost of the employee-only coverage of the plan, although this maximum extends to 50% for programs designed to reduce or prevent nicotine use.<sup>151</sup> If an employee's dependents may participate in the program, then the total cost considered may be the cost of the coverage the employee and the dependents are enrolled in, typically a family coverage.

### *B. The ADA and GINA Prohibit Potentially Discriminatory Health Inquiries*

While the ACA encourages the development of workplace wellness programs, two major federal laws might limit their impact on employees. The ADA was designed to protect people with disabilities from discrimination on that basis.<sup>152</sup> Similarly, GINA was intended to protect people from discrimination on the basis of their genetic information.<sup>153</sup> Both protect individuals from adverse actions taken on the basis of their personal health information, but there are limits to the protection each law provides in the context of workplace wellness programs.

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148. See 26 C.F.R. §§ 54.9802-1(f) (2016); 29 C.F.R. § 2590.702 (2016); 45 C.F.R. § 146.121 (2016). These regulations were amended by the Public Health Service Act but retained the same basic categorization.

149. *Id.*

150. 26 C.F.R. §§ 54.9802-1(b)(2)(ii) and (c)(3) (2016); 29 C.F.R. §§ 2590.702(b)(2)(ii) and (c)(3) (2016); 45 C.F.R. §§ 146.121(b)(2)(ii) and (c)(3) (2016).

151. See 71 Fed. Reg. 75,018 (Dec. 13, 2006); see also 77 Fed. Reg. 70,623 (Nov. 26, 2012).

152. American with Disabilities Act of 1990 § 102, 42 U.S.C.A. § 12112 (West 2016).

153. Genetic Information Nondiscrimination Act of 2008, 42 U.S.C.A. §§ 2000ff (West 2016).

Both the ADA and GINA contain prohibitions on employer inquiries into certain aspects of employees' health and medical history, subject to certain exemptions.<sup>154</sup> Although employers cannot make inquiries that might reveal disability-related health information as a general matter, both the ADA and GINA permit such inquiries when they are made as part of workplace wellness programs, under certain conditions, and when employers offer incentives that amount to no more than 30% of the employee's plan's cost.

### *1. The ADA Restricts Unnecessary Medical Inquiries at Work*

Under the ADA, employers may not discriminate against people with regard to their employment on the basis of any actual, perceived or historical disability.<sup>155</sup> This protection against disability-based discrimination encompasses the collection of information that could indicate the presence or extent of a disability. The ADA provides that:

A covered entity shall not require a medical examination and shall not make medical inquiries of an employee as to whether such employee is an individual with a disability or as to the nature and severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.<sup>156</sup>

Asking employees to reveal information about their own health, including their medical history and whether they are taking any prescription drugs, could elicit information about a disability.<sup>157</sup> In contrast, more general questions about an employee's wellbeing, including the employee's use of alcohol or tobacco, or a request for contact information in case of a medical emergency are not considered to be disability-related inquiries.<sup>158</sup>

There are two exceptions to these protections under the ADA. First, employers and other covered entities may gather information about an employee's health and medical history as part of a voluntary wellness program.<sup>159</sup> Specifically, covered entities may "conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees

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154. 42 U.S.C. § 12112(d) (2012); 42 U.S.C. § 2000ff-1(b) (2012).

155. 42 U.S.C.S. § 12112(a) (Lexis 2016).

156. 42 U.S.C. § 12112(d)(4)(A) (2012).

157. 42 U.S.C. § 12201(c) (2012).

158. *Id.*

159. U.S. EQUAL EMP. OPPORTUNITY COMM'N, ENFORCEMENT GUIDANCE: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS OF EMPLOYEES UNDER THE AMERICANS WITH DISABILITIES ACT (ADA) (2000), <http://www.eeoc.gov/policy/docs/guidance-inquiries.html>.

at that work site.”<sup>160</sup> These inquiries need not be job-related or, indeed, related in any way to job performance as long as the information acquired is kept confidential and separate from personnel records. A voluntary wellness program, according to the EEOC’s Enforcement Guidance, is one in which “an employer neither requires participation nor penalizes employees who do not participate.”<sup>161</sup>

Second, there is a safe harbor for wellness programs conducted as part of a “bona fide” insurance plan.<sup>162</sup> The ADA provides that certain sections of the law, including the prohibition on medical exams and inquiries that are not “job-related and consistent with business necessity,” will not operate to restrict “a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law.”<sup>163</sup> In other words, a wellness program that is offered in conjunction with a benefit plan, whether that plan is administered by an employer, an employer’s agent, a health insurer, or any other entity, is exempted from the general ADA restrictions on unnecessary medical examinations and inquiries in the workplace. An employer-sponsored health insurance plan would be an example of a “benefit plan” that this section accommodates.

## 2. *GINA Restricts Employers’ Collection and Use of Genetic Information*

GINA limits the collection of information that might serve as a basis for the kind of discrimination the statute prohibits. Under GINA, it is “an unlawful practice for an employer to request, require or purchase genetic information with respect to an employee or a family member of the employee.”<sup>164</sup>

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160. 42 U.S.C. § 12112(d)(4)(B) (2012); *see also* U.S. EQUAL EMP. OPPORTUNITY COMM’N, *supra* note 159. The ADA provides two other exceptions to the prohibition against seeking medical information from employees. It allows for examinations and inquiries that are “job-related and consistent with business necessity.” 42 U.S.C. § 12112(d)(4)(A). It also permits inquiries “into the ability of an employee to perform job-related functions.” 42 U.S.C. § 12112(d)(4)(B).

161. *Id.*; *see* H.R. REP. NO. 101-485, at 75 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 357 (“As long as the programs are voluntary and the medical records are maintained in a confidential manner and not used for the purpose of limiting health insurance eligibility or preventing occupational advancement, these activities would fall within the purview of accepted activities.”).

162. 42 U.S.C. § 12201(c).

163. *Id.*

164. 42 U.S.C. § 2000ff-1(b) (2012).



“Genetic information” has an unusually broad definition under this statute. It includes not only genetically encoded information, such as that which might be revealed by genetic testing, but also “the manifestation of a disease or disorder in the family members of an individual.”<sup>165</sup> The EEOC polices this by suing employers who ask about family medical history in any employment-related context, with few exceptions. For example, in December 2015, the EEOC alleged that Joy Mining Machinery violated GINA by asking job applicants whether they had a family medical history of “TB, Cancer, Diabetes, Epilepsy [and] Heart Disease.”<sup>166</sup> One month later, the defendant agreed to a settlement that limited its ability to make such inquiries in the employment context.<sup>167</sup>

GINA’s exception to these prohibitions allows the collection of “genetic information,” which is fairly broad, if that information is being provided voluntarily. Covered entities may collect “genetic information” where: (1) “health or genetic services are offered by the employer, including services offered as part of a wellness program”; (2) “the employee provides prior, knowing, voluntary and written authorization”; (3) “only the employee . . . and the licensed health care professional or board certified genetic counselor involved in providing such services receive individually identifiable information concerning the results of such services”; and (4) “individual identifiable genetic information provided . . . is only available for purposes of such services and shall not be disclosed to the employer except in aggregate terms that do not disclose the identity of specific employees.”<sup>168</sup> In other words, GINA allows employers to ask for health-related information as part of a wellness program if the employee voluntarily agrees to its collection and the information is aggregated when passed on to the employer.

### *C. Regulatory Guidance Has Expanded the Range of Permissible Health Inquiries*

Regulatory guidance helps employers and courts determine the proper interpretation of federal regulations such as the ADA, GINA and ACA. The EEOC has offered both formal and informal guidance on the meaning of key terms in these regulations in the context of

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165. *Id.*

166. Press Release, U.S. Equal Emp. Opportunity Comm’n, EEOC Sues Joy Mining Machinery for Violating Genetic Non-Discrimination Act (Dec. 4, 2015), <http://www.eeoc.gov/eeoc/newsroom/release/12-4-15a.cfm>.

167. *Id.*

168. 42 U.S.C. § 2000ff-1(b)(2) (2012).

workplace wellness programs. This guidance is especially important because of the confusing and to some extent conflicting definitions of a “voluntary” and therefore permissible wellness program.

### *1. The Statutory Definition of “Voluntary” Wellness Programs*

What does “voluntary” mean in the context of the ADA and GINA? Before the passage of the ACA, the EEOC’s guidance and federal regulations provided similar definitions for “voluntary” under both statutes. According to the EEOC’s enforcement guidance on medical exams and inquiries under the ADA, a program is “voluntary” “as long as the employer neither requires participation nor penalizes employees who do not participate.”<sup>169</sup>

The regulations implementing GINA were similar in their definition of “voluntary.” An employer may offer incentives for completing assessments that reveal health information without violating GINA so long as “the covered entity makes clear . . . that the inducement will be made available whether or not the participant answers questions regarding genetic information.”<sup>170</sup> In other words, the employer cannot condition receipt of the incentive upon the provision of genetic information. This would limit the effectiveness of any incentive-based wellness program, since the employer would not be able to distinguish between employees who do and do not provide the information requested.

EEOC staff addressed the definition of “voluntary” under the ADA in two informal discussion letters in 2009. On March 6, 2009, the EEOC’s Associate Legal Counsel Peggy Mastroianni responded to an inquiry as to whether a certain county could require its employees to take a clinical health risk assessment as a condition of enrollment in its health plan.<sup>171</sup> The assessment included a health risk questionnaire, taking a blood pressure test and providing blood for use in a panel screen.<sup>172</sup> Employees who refused to take the assessment could not enroll in the health plan.<sup>173</sup>

Ms. Mastroianni counseled that this requirement would likely violate the ADA. While disability-related inquiries are permissible in

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169. Although the ADA was amended in 2008, this Guidance apparently remains in effect.

170. 29 C.F.R. § 1635.8(b)(2)(ii) (2012).

171. U.S. EQUAL EMP. OPPORTUNITY COMM’N, INFORMAL DISCUSSION LETTER: ADA: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS; HEALTH RISK ASSESSMENT (Mar. 6, 2009), [http://www.eeoc.gov/eeoc/foia/letters/2009/ada\\_disability\\_medexam\\_healthrisk.html](http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html).

172. *Id.*

173. *Id.*

connection with a voluntary wellness program, she referred to the Enforcement Guidance noting that “a wellness program is voluntary if employees are neither required to participate nor penalized for non-participation.”<sup>174</sup> Under the county’s program, in contrast, “an employee’s decision not to participate in the health risk assessment results in the loss of the opportunity to obtain health coverage through the employer’s plan. Thus . . . the program would not be voluntary, because individuals who do not participate in the assessment are denied a benefit (i.e., penalized for non-participation) as compared to employees who participate in the assessment.”<sup>175</sup> In other words, her informal guidance was that a penalty for refusing to answer a disability-related inquiry in a wellness program made the program involuntary, thereby disqualifying it from an exception to the ADA’s general prohibition against such inquiries in an employment context.

Ms. Mastroianni gave similar advice in another informal opinion letter five months later. In that instance, the EEOC had been asked whether an employer could require employees to complete a health risk assessment questionnaire comprised of more than 100 questions in categories such as “Family Health History” and “Health Choices-Physical Activity.”<sup>176</sup> After reviewing the ADA’s general prohibition on disability-related inquiries that are not job-related and consistent with medical necessity as well as the safe harbor for voluntary wellness programs, the letter opined that the plan probably violates the ADA.<sup>177</sup> Even if the questionnaire were part of a wellness program, it explained, such a program “is not voluntary because it penalizes any employee who does not complete the questionnaire by making him or her ineligible to receive reimbursement for health expenses.”<sup>178</sup> The letter concluded that “the Commission believes that the ADA prohibits your client from making disability-related inquiries or requiring a medical examination under the circumstances you have described.”<sup>179</sup> In a footnote, Ms. Mastroianni observed that GINA, which would go into effect the following year, would also likely prohibit what the employer had described as questions regarding family medical history.<sup>180</sup>

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174. *Id.*

175. *Id.*

176. U.S. EQUAL EMP. OPPORTUNITY COMM’N, INFORMAL DISCUSSION LETTER: ADA: HEALTH RISK ASSESSMENT (Aug. 10, 2009), [http://www.eeoc.gov/eeoc/foia/letters/2009/ada\\_health\\_risk\\_assessment.html](http://www.eeoc.gov/eeoc/foia/letters/2009/ada_health_risk_assessment.html).

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

Taken together, these guidance letters suggested that conditioning enrollment in a health plan on completion of a health risk assessment would violate the ADA in the EEOC's view.

## 2. *The EEOC Limited the ADA and GINA's Protections for Wellness Programs*

Scholars noted the potential conflicts between the ACA's promotion of public health, in part through expanding the permissible scope of wellness programs, and the ADA's prohibition on medical inquiries, as well as GINA's protection of genetic information privacy.<sup>181</sup> In 2015, the EEOC attempted to clarify the interaction of these laws. It issued two proposed rules designed to help employers understand how they may offer incentives to employees for health-related information through a wellness program without violating the ADA or GINA. Neither rule has been finalized as of this writing, although the comment periods for both have closed.

In April 2015, the EEOC issued a Notice of Proposed Rulemaking (NPRM) designed to clarify the permissible use of employee incentives in wellness programs with regard to the ADA.<sup>182</sup> Observing that the ADA allows covered entities to "conduct voluntary medical examinations and inquiries, including voluntary medical histories, which are part of an employee health program available to employees at that work site," it went on to say that wellness programs were, in its view, "employee health programs" within the meaning of that statute.<sup>183</sup>

As noted above, prior to the passage of the ACA, the EEOC's guidance on whether a wellness program is "voluntary" under the ADA had stated that "a wellness program is 'voluntary' as long as an employer neither requires participation nor penalizes employees who do not participate."<sup>184</sup> According to that guidance, it conceded, one might "plausibl[y]" conclude that offering rewards or penalties for participation or nonparticipation in wellness programs might violate the ADA.<sup>185</sup>

In this NPRM, however, the EEOC sought to clarify that offering incentives in exchange for employee participation would not necessa-

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181. *See, e.g.,* Bard, *supra* note 141.

182. Amendments to Regulations Under the Americans with Disabilities Act, 80 Fed. Reg. 21,659 (proposed Apr. 20, 2015).

183. *Id.*

184. *See* Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,157, 33,165 (June 3, 2013).

185. *Id.*

rily render a wellness program involuntary.<sup>186</sup> It proposed a rule allowing an employer to offer incentives up to “30 percent of the total cost of employee-only coverage, whether in the form of a reward or penalty, to promote an employee’s participation in a wellness program that includes disability-related inquiries or medical examinations as long as participation is voluntary.”<sup>187</sup>

What would ensure that the program was truly voluntary, according to the NPRM, was the mandated inclusion of a notice explaining, among other things, what information would be collected and how it would be used.<sup>188</sup> In addition, the information collected would be disclosed only in aggregate form, except as needed to administer the plan.<sup>189</sup>

Six months after issuing the NPRM regarding the incentives under the ADA, the EEOC issued a similar NPRM regarding incentives under GINA.<sup>190</sup> Under previous EEOC guidance on GINA, a wellness program could not require employees to provide genetic information about themselves or their family members in order to receive incentives. In October 2015, however, the EEOC proposed a rule clarifying that employers may penalize employees who do not provide information about their spouse’s health information without violating the terms of GINA.<sup>191</sup>

Under Title II of GINA, covered employers may not use genetic information to make employment decisions.<sup>192</sup> “Genetic information,” as the statute defines it, includes not only an individual’s genetic tests but also the “manifestation of a disease or disorder in family members of such individual.” GINA forbids employers to ask for, require, or buy the genetic information of an employee or an employee’s family member unless one of six exceptions applies.<sup>193</sup> One of those exceptions is when the employee authorizes the employer’s acquisition of this information through a wellness program, but only if any individually identifiable information gathered as a result is aggregated so that it anonymizes that information.<sup>194</sup> In other words, GINA allows em-

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186. 80 Fed. Reg. 21,659.

187. *Id.*

188. *Id.*

189. *Id.*

190. Press Release, U.S. Equal Emp. Opportunity Comm’n, EEOC Issues Proposed Rule to Amend Title II of GINA (Oct. 29, 2015), <http://www.eeoc.gov/eeoc/newsroom/release/10-29-15.cfm>.

191. *Id.*

192. Genetic Information Nondiscrimination Act, 42 U.S.C. § 2000ff-1(a) (2012).

193. *Id.* § 2000ff-1(b).

194. *Id.* § 2000ff-1(b)(2).

employers to ask for genetic information when the employee participates in a wellness program, but the employers cannot disclose it to third parties.

The EEOC's proposed rule clarifies that an employer can offer an incentive to an employee's spouse to provide health information as part of a wellness program as long as the family member is receiving "health or genetic services" that are "reasonably designed to promote health or prevent disease." That language is identical to the ACA's definition of a qualifying health-contingent wellness program. In addition, the total amount of the incentive is capped at 30% of the cost of the plan in which the employee and dependents are enrolled. This, too, is identical to the cap on incentives set by the ACA. Employers who offer incentives for wellness program participation, as the ACA defines it, will now have a clearer understanding of when they may offer those incentives to employees' spouses as well as the employees themselves.

The employer may not, however, offer incentives for the genetic information of an employee's children. In the Questions and Answers that accompanied the NPRM, the EEOC explained that the risk of discrimination against an employee is higher when the employer has access to the genetic information of the employee's children than when the employer has similar information about the employee's spouse. It noted that:

There is minimal, if any, chance of determining information about an employee's genetic make-up or predisposition to disease from information about current or past health status of the employee's spouse. By contrast, there is a significantly higher likelihood of discovering information about an employee's genetic make-up or predisposition to disease from information about the current or past health status of the employee's children.<sup>195</sup>

As the preceding sections show, the EEOC's position on whether a wellness program is "voluntary" for ADA purposes has evolved significantly. In its 2009 informal guidance letters, the EEOC determined that conditioning access to a wellness plan on completing a health risk assessment would render that plan "involuntary" and therefore violate the ADA. In its 2015 guidance, however, the EEOC suggested that a wellness plan offering certain financial incentives for completing

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195. *Questions and Answers: The Equal Employment Opportunity Commission's Notice of Proposed Rulemaking on Title II of the Genetic Information Nondiscrimination Act and Incentives in Employer Wellness Programs for Employees' Spouses to Provide Their Current or Past Health Status Information*, U.S. EQUAL EMP. OPPORTUNITY COMM'N, <https://www.eeoc.gov/laws/regulations/qanda-gina-wellness.cfm> (last visited Mar. 5, 2017).

health risk assessments would not violate the ADA because it would still qualify as “voluntary.”

### 3. *Congress Left Inherent Tension Between the ACA and ADA/GINA Unresolved*

Congress could have avoided a conflict between the ADA and GINA’s prohibitions on involuntary health assessments and the ACA’s encouragement of incentives for health assessments by including a wide carve-out for all wellness programs under those laws, effectively making the ACA’s incentive programs the law of the land. In passing the ACA, Congress could have exempted all wellness programs from the ADA or GINA prohibitions. It chose not to do so. According to Jennifer Mathis, testifying before the EEOC on behalf of the Consortium of Citizens with Disabilities in 2013, Congress considered and rejected the following language in the ACA, which would have provided an umbrella exemption:

Nothing in the Americans with Disabilities Act of 1990, title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, or the Genetic Information Non-discrimination Act of 2008 shall be construed to prohibit a covered entity from adopting, sponsoring, administering, or providing products or services in connection with, or relating to, programs of health promotion or disease prevention that requests individuals to participate in medical examinations, answer medical inquiries, or complete health risk assessments or questionnaires, if such requirements are otherwise authorized under this Act.<sup>196</sup>

If Ms. Mathis’ statements are true, it is not clear why Congress would not have passed such broad exemptions. In failing to do so, Congress left open the possibility of tension between the ADA and GINA on one hand and the ACA/HIPAA on the other.

### 4. *There Is Little Explicit Justification for the Thirty Percent Rule*

Whether a wellness program that elicits sensitive health information is truly “voluntary” under ADA and GINA is a critical issue. Writing in 2014, a senior attorney at the EEOC noted that whether the ADA, GINA, HIPAA and the ACA “work as a coherent whole or whether there is an inherent tension in the standards they employ . . .

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196. *Wellness Programs Under Federal Equal Employment Opportunity Laws: Public Meeting Before the U.S. Equal Emp. Opportunity Comm’n* (May 8, 2013) (written testimony of Jennifer Mathis, Director of Programs, Bazelon Center for Mental Health Law, On Behalf of the Consortium of Citizens with Disabilities), <http://www.eeoc.gov/eeoc/meetings/5-8-13/mathis.cfm>.

turns, in large part, on how one interprets the term ‘voluntary’ in the ADA and GINA.”<sup>197</sup> His analysis of what “voluntary” means under these statutes presaged the EEOC’s 2015 guidance on this issue, discussed in Part III.C.2, which may not be surprising given his position.<sup>198</sup> He wrote that “[i]f one believes that the presence of a penalty or reward that meets the ACA and HIPAA standards does not impact the voluntariness of the program, then there is no tension. The laws work in perfect harmony.”<sup>199</sup> This school of thought posits that a financial incentive of no more than 30% of the cost of coverage is not so large as to be coercive of employee participation or to render them involuntary.

The Secretaries of Labor, Health and Human Services, and Treasury agreed with this position.<sup>200</sup> The preamble to the final rule on Incentives for Nondiscriminatory Wellness Programs in Group Health Plans provides some explanation as to how they reached this conclusion.<sup>201</sup> HIPAA had included a prohibition against discrimination in group health plans, but provided an exception for wellness programs. Implementing this provision in 2006, regulators included a limit on wellness program incentives not to exceed 30% of the cost of coverage.<sup>202</sup> The 2013 preamble notes that the Department of Labor and the Department of Health and Human Services believed that expanding the permissible incentive limit from 20% to 30% (or 50% for programs associated with reducing tobacco use) would have a minimal impact because so few wellness programs came close to reaching even the 20% limit.<sup>203</sup> It said that “the usual reward percentage ranges from three to 11 percent.”<sup>204</sup> In support of this statement, it cited a 2012 survey finding that “the maximum premium differential offered in a survey respondent was 16 percent.”<sup>205</sup>

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197. Blue, *supra* note 137, at 382.

198. The biographical footnote for his article noted that the EEOC had held a hearing on wellness programs prior to his article’s publication, but perhaps disingenuously denied giving any indication of the EEOC’s plans. “The author understands that persons might be tempted to scrutinize this article for hints about what the Commission may do in this area,” he wrote. “However, the author stresses that this piece contains no such hints.” *Id.* at 367 n.a1.

199. *Id.* at 382.

200. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,157 (June 3, 2013).

201. *Id.* at 33,158.

202. *Id.*

203. 77 C.F.R. § 70,620 (2012).

204. *Id.*

205. *Id.*



This data, however, does not fully explain why regulators increased the permissible incentive level to 30%. The fact that employers had not reached the 20% maximum incentive permissible under prior HIPAA guidelines does not necessarily suggest that an increase in permissible incentives would have no effect on workplace wellness program participants.<sup>206</sup> Indeed, that data might well argue against increasing the limit on incentives, since so few employers approached even the existing upper limit.

#### IV.

#### RECENT CASE LAW ENABLES MORE EXPANSIVE WELLNESS PROGRAMS

In recent years, courts have been asked to decide whether specific wellness programs violated the provisions of the ADA and GINA. Although the case law does not speak uniformly, most courts have interpreted the exceptions to the ADA so broadly as to increase the ability of employers to impose wellness programs on their employees.

In *Seff v. Broward County*, the United States District Court for the Southern District of Florida was asked to decide whether penalizing employees who refuse to participate in a wellness program renders that program involuntary for ADA purposes.<sup>207</sup> The plaintiff, a county employee, alleged ADA violations stemming in part from his employer's surcharge of twenty dollars on each bi-weekly pay check for employees who were covered by its insurance plan but refused to participate in its wellness program.<sup>208</sup> The court did not reach the question of whether the twenty dollar surcharge rendered the program "involuntary" within the meaning of the ADA because it affirmed that the practice fell within the ADA's safe harbor provisions for a "bona fide benefit plan" that is "based on underwriting risks, classifying risks, or administering such risks."<sup>209</sup> The court reasoned that the wellness program at issue was "a term of the County's group health plan" that was designed to help develop "present and future benefit plans using accepted principles of risk management."<sup>210</sup> The aggregate data collected through the wellness program allowed the County to design more useful plans for future health coverage, in the court's

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206. *Id.*

207. *Seff v. Broward County*, 778 F. Supp. 2d 1370, 1372 (S.D. Fla. 2011), *aff'd sub nom.*, *Seff v. Broward County*, 691 F.3d 1221 (11th Cir. 2012).

208. *Id.*

209. *Id.*; 42 U.S.C. § 12201 (2012).

210. *Seff*, 778 F. Supp. 2d. at 1373.

view.<sup>211</sup> The court also noted that the wellness program helped mitigate risks of illness in that it encouraged employees to take better care of their own health.<sup>212</sup> Its rationale was “that encouraging employees to get involved in their own healthcare leads to a more healthy population that costs less to insure.”<sup>213</sup> For these reasons, the court determined that the program at issue fell within the insurance safe harbor of the ADA.<sup>214</sup>

The reasoning in *Seff* could apply to any wellness program that is part of a health insurance plan. It is hard to imagine a wellness program that is not either directly associated with a health insurance plan or designed to mitigate the risks of higher health care costs.

### A. *The EEOC’s Triple Play: Flambeau, Orion and Honeywell*

The EEOC was not pleased with the outcome in *Seff*,<sup>215</sup> and may have hoped that it was an isolated decision. In 2014, the EEOC filed complaints alleging that three employers had violated the ADA by penalizing employees who did not take part in the employers’ wellness plans. The first of those three cases to be decided, *EEOC v. Flambeau*, expressly relied on *Seff* in ruling against the EEOC, as discussed above in Part I.A.

#### I. *EEOC v. Orion*

*EEOC v. Orion* was the first lawsuit filed by the EEOC directly challenging a workplace wellness program under the ADA.<sup>216</sup> On August 20, 2014, the EEOC sued Orion Energy Systems, an energy-efficient lighting manufacturer.<sup>217</sup> Orion implemented a wellness program in March 2009.<sup>218</sup> The program required employees to use a “range of

211. *Id.*

212. *Id.*

213. *Id.* at 1374.

214. *Id.* at 1375.

215. See Memorandum in Support of EEOC’s Application for Temporary Restraining Order & an Expedited Preliminary Injunction, *EEOC v. Honeywell Int’l Inc.*, No. 0:14-cv-04517, 2014 WL 5795481 (D. Minn. Nov. 6, 2014); see also Amendments to Regulations Under the Americans with Disabilities Act, 80 Fed. Reg. 21,659, 21,622 n.24 (proposed Apr. 20, 2015) (“The Commission does not believe that the ADA’s ‘safe harbor’ provision applicable to insurance, as interpreted by the court in *Seff v. Broward County* . . . is the proper basis for finding wellness program incentives permissible.”).

216. Press Release, U.S. Equal Emp. Opportunity Comm’n, EEOC Lawsuit Challenges Orion Energy Wellness Program and Related Firing of Employee (Aug. 20, 2014), <http://www.eeoc.gov/eeoc/newsroom/release/8-20-14.cfm>.

217. *Id.*

218. Complaint ¶ 10, *EEOC v. Orion Energy Sys.*, No. 1:14-cv-1019 (E.D. Wis. Aug. 20, 2014).

motion” fitness machine at Orion and complete a health risk assessment.<sup>219</sup> The assessment required the employees to self-disclose their medical history and included a blood test.<sup>220</sup> Under the terms of Orion’s health insurance benefit, Orion would pay the full cost of the plan for employees who completed both the preliminary fitness test and the health risk assessment.<sup>221</sup> Employees who refused to complete the assessment had to pay the full cost of the health plan themselves.<sup>222</sup> Employees who refused to complete the fitness test had \$50 deducted from their pay.<sup>223</sup>

Orion employee Wendy Schobert objected to participating in either part of the program.<sup>224</sup> According to the EEOC complaint, Schobert “questioned whether the health risk assessment was voluntary and whether medical information obtained in connection with it was going to be maintained as confidential.”<sup>225</sup> In response, Orion called Schobert into a meeting to “quash any potential ‘attitude’ issue of hers relating to the wellness program” and ordered her not to express her opinions about the wellness program to her co-workers.<sup>226</sup> She declined to participate, and was compelled to pay more than \$400 per month in order to continue her single coverage health benefits at the same level as other employees.<sup>227</sup> She was also fined \$50 per month for her noncompliance with the fitness test.<sup>228</sup> She was fired the month after objecting to the test because, the EEOC alleged, she declined to participate in the wellness program.<sup>229</sup> Orion moved for summary judgment in December 2015.<sup>230</sup>

## 2. EEOC v. Honeywell

Perhaps the most controversial 2014 wellness program lawsuit was the one that EEOC filed against Honeywell International on Octo-

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219. *Id.*

220. *Id.* ¶ 11.

221. *Id.*

222. *Id.*

223. *Id.*

224. *Id.*

225. *Id.* ¶ 13.

226. *Id.* ¶ 14.

227. *Id.* ¶ 17.

228. *Id.*

229. *Id.* ¶ 21.

230. Defendant’s Motion for Summary Judgment, EEOC v. Orion Energy Sys., No. 1:14-cv-1019 (E.D. Wis. Dec. 1, 2015).

ber 27, 2014.<sup>231</sup> In September 2014, Honeywell had informed its employees that they would have to undergo biometric testing, including a blood draw, for the 2015 health benefit year.<sup>232</sup> If their spouses were covered under the Honeywell plan, they would also have to submit to this test.<sup>233</sup> If the employees or covered spouses refused to take the test, they would face a series of penalties.<sup>234</sup> First, the employees would have to forgo Honeywell's contributions to their health savings accounts, which can be up to \$1500.<sup>235</sup> The employees would also face a \$500 surcharge on their medical plan costs for the 2015 benefit year.<sup>236</sup> Additionally, the employee would be charged \$1000 as a "tobacco surcharge" regardless of whether the employee declined the test for reasons other than smoking.<sup>237</sup> The employee's spouse would be charged another \$1000 "tobacco surcharge" for refusing to submit to the test for any reason.<sup>238</sup> In sum, Honeywell employees who refused to submit to the biometric tests could have lost \$4000 in fees and foregone health savings account contributions.<sup>239</sup> Employees Keenan Hall and SueAnne Schwartz filed a discrimination charge with the EEOC based on this plan.<sup>240</sup>

The EEOC asked the United States District Court for the District of Minnesota to enjoin Honeywell from imposing penalties on employees who refuse to consent to biometric testing, alleging that Honeywell's practice of doing so violated ADA and GINA, among other laws.<sup>241</sup> The testing was not voluntary, the EEOC argued, because of the substantial financial penalty associated with noncompliance.<sup>242</sup>

In its defense, Honeywell responded that the imposition of surcharges did not render the testing program involuntary.<sup>243</sup> Alternatively, it characterized its biometric testing program as part of its

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231. Petition for a Temporary Restraining Order and Preliminary Injunction, EEOC v. Honeywell Int'l Inc., No. 0:14-cv-04517, 2014 WL 5462363 (D. Minn. Oct. 27, 2014).

232. *Id.*

233. *Id.* ¶ 10.

234. *Id.* ¶ 14.

235. *Id.*

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.* ¶ 15.

240. *Id.* ¶¶ 18–19.

241. *Id.*

242. *Id.*

243. Memorandum of Law in Opposition to Plaintiff's Motion for Temporary Restraining Order and Expedited Preliminary Injunction at 32, EEOC v. Honeywell Int'l Inc., No. 0:14-cv-04517, 2014 WL 6724236 (D. Minn. Oct. 30, 2014).

health insurance plan and therefore protected by the ADA's insurance safe harbor.<sup>244</sup>

Most compellingly, Honeywell pointed out that its testing program complied with the HIPAA Final Wellness Program Regulations.<sup>245</sup> These regulations, Honeywell argued, expressed Congressional approval for exactly the kind of wellness program Honeywell established.<sup>246</sup> The fact that the EEOC's Enforcement Guidance may have offered inconsistent advice, Honeywell argued, did not outweigh the clear mandate set by the HIPAA Final Wellness Program Regulations.<sup>247</sup>

On November 6, 2014, the court denied the EEOC's motion for injunctive relief, noting that there was no threat of irreparable harm since the only penalty associated with Honeywell's program was financial.<sup>248</sup> If the EEOC prevailed, the court observed, the employees could be made whole through monetary damages.<sup>249</sup> In declining to reach the merits, the court noted that "[r]ecent lawsuits filed by the EEOC highlight the tension between the ACA and the ADA and signal the necessity for clarity in the law so that corporations are able to design lawful wellness programs and also to ensure that employees are aware of their rights under the law."<sup>250</sup>

The EEOC was responsive to these concerns. Less than six months after the court's ruling on its motion in *EEOC v. Honeywell*, the EEOC released its proposed rule providing guidance to employers on designing wellness programs that comply with the ADA, discussed above.<sup>251</sup> The Honeywell biometric testing program appears to comply with the ADA compliance guidelines that the EEOC issued shortly after suing Honeywell for violating the ADA.<sup>252</sup>

### 3. *Broadening the Definition of "Voluntary": Van Patten and Watterson*

Two other recent cases illustrate the expanded scope of workplace wellness programs. In *Van Patten v. Oregon*, the Oregon Court

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244. *Id.* at 4.

245. *Id.* at 28–29.

246. *Id.* at 29.

247. *Id.* at 32.

248. Memorandum Opinion and Order at 3, *EEOC v. Honeywell Int'l Inc.*, No. 0:14-cv-04517, 2014 WL 5795481 (D. Minn. Nov. 6, 2014).

249. *Id.* at 2–3.

250. *Id.*

251. Amendments to Regulations Under the Americans with Disabilities Act, 80 Fed. Reg. 21,659 (proposed Apr. 20, 2015).

252. *See id.*

of Appeals affirmed that the state of Oregon could require employees to submit to health questionnaires as part of the state's own wellness program without violating the ADA.<sup>253</sup> In *Watterson v. Garfield Beach CVS LLC*, the United States District Court for the Northern District of California held that an employer's health insurance plan that included a wellness program "with strings attached," in the court's words, was voluntary, and therefore an employee could not seek compensation for time spent complying with the terms of the program.<sup>254</sup>

*a. Van Patten v. Oregon*

In *Van Patten*, five state employees held state-sponsored health insurance administered by the Public Employees' Benefit Board (PEBB).<sup>255</sup> They claimed that the state's insurance program violated the ADA and an analogous state law by requiring them to disclose disabilities in response to a self-assessment questionnaire.<sup>256</sup> The state defendants won on summary judgment, and the plaintiffs appealed.<sup>257</sup>

In reviewing the facts of the case, the Oregon Court of Appeals noted that there was no dispute that the insurance program "urges" state employees to fill out an online health risk assessment questionnaire.<sup>258</sup> The questionnaire includes "questions that are highly personal and could indicate the presence of a disability—for example, whether the employee has cancer, hepatitis B, a sexually transmitted infection, depression, or a host of other conditions."<sup>259</sup> After employees fill out the assessment, their answers are forwarded to administrators (covered by the ADA) who aggregate the responses and forward the aggregated data to PEBB.<sup>260</sup> PEBB and the state employers learn who has taken the assessment and who has not, but the data itself is aggregated and anonymized.<sup>261</sup> This anonymization apparently was important to the court, which underscored the fact that "neither PEBB nor any state employer receives the results of an individual's assess-

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253. *Patten v. State*, 359 P.3d 469 (Or. Ct. App. 2015).

254. *Watterson v. Garfield Beach CVS LLC*, 120 F. Supp. 3d 1003, 1008 (N.D. Cal. 2015).

255. *Patten*, 359 P.3d at 490.

256. *Id.*

257. *Id.*

258. *Id.*

259. *Id.*

260. *Id.* at 492.

261. *Id.*

ment, and the employee's health care provider receives the information only if the employee affirmatively so authorizes."<sup>262</sup>

In addition to answering the questions, the self-assessment "required" the users to take two "health actions," presumably designed to improve their physical and/or mental wellbeing.<sup>263</sup> While the court did not specify what these might be, the Providence insurance website for PEBB members lists examples of health actions that would satisfy the plan's requirements.<sup>264</sup> Several of these include engaging further with the Providence insurer's own programs, such as using their health coaching service, enrolling in an "exercise rewards program" that provides a subsidy if you use a qualified health club at least twelve times per month, and using a Skype-based medical treatment service.<sup>265</sup> The court noted that the "agreement is not policed," in that users are not required to submit proof of their actions.<sup>266</sup> In other words, employees may lie about whether they have complied with the terms of the program. Because many of the health action options involve providing more data to the insurer, however, it may not be wholly accurate to say that PEBB could not gather more information about employee participation in at least those options.

Refusing to take the assessment came with a price tag. Employees who did not complete the assessment paid \$17.50 more per month (for individuals) or \$35 more per month (for couples) on their health insurance.<sup>267</sup> In addition, non-participants paid \$100 more in deductibles than participants.<sup>268</sup> Importantly, the parties in *Van Patten* agreed that the financial incentives attached to participating in the assessment meant that such participation was not "voluntary" as the ADA defines it.<sup>269</sup>

The defendants had another out, however. The ADA provides that a covered entity "shall not . . . make inquiries of an employee as

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262. *Id.* The court did not say, in its ruling, whether the employees were "urged" to provide this consent as they were "urged" to complete the self-assessment questionnaire. If they were, one could question the genuineness of such consent.

263. *Id.*

264. *Get Healthier, Together with HEM 2016*, PROVIDENCE HEALTH PLAN (last visited Jan. 15, 2016), <https://healthplans.providence.org/members/member-groups/pebb/health-engagement-model/>; *Exercise Rewards Program*, PROVIDENCE HEALTH PLAN (last visited Jan. 15, 2016), <https://healthplans.providence.org/~media/files/providence%20hp/pdfs/pebb/documents/exercise%20rewards%20program.pdf>; *Health express*, Providence Health Plan (last visited Jan. 15, 2016), <https://healthplans.providence.org/html/pebb-health-express/>.

265. *Id.*

266. *Patten*, 359 P.3d at 492.

267. *Id.*

268. *Id.*

269. *Id.*

to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.”<sup>270</sup> The Oregon state employers contended that the assessment did not “make inquiries” within the meaning of the statute.<sup>271</sup>

Declaring this a case of first impression, the court followed the methodology prescribed for such cases, which directs the court to “read the words in their context and with a view to their place in the statutory scheme.”<sup>272</sup> The court conceded that “the assessment asks employees to answer questions,” but noted that that did “not compel the conclusion that the questions are inquiries.”<sup>273</sup> Noting that the dictionary defines “inquiry” as “seeking truth, information, or knowledge about something,” the court suggested that the defendants’ subjective skepticism about receiving accurate answers complicated the issue.<sup>274</sup> “If the person or entity asking a question knows that it will not receive a response to that question, then it makes no sense to regard the questioner as ‘seeking truth, information, or knowledge about anything.’”<sup>275</sup> It is not clear why the court assumed that the insurers knew that they would not receive accurate information; indeed, it is hard to understand why insurers would implement an assessment at all in that case.

The court went on to reject the plaintiffs’ claims that the assessment violated their right to privacy of their personal medical information.<sup>276</sup> It first expressed doubt that such rights exist.<sup>277</sup> Even so, the court found that the defendants had important interests in “maintaining the health of its work force, lowering health insurance costs, and planning effective and efficient future health plans.”<sup>278</sup> One purpose of collecting this data was to lower the state’s health insurance costs by encouraging employees to adopt healthier habits.<sup>279</sup> Even if the respondents had a cognizable interest in informational privacy, the context of the data collection mitigated any risk of disclosure, in the

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270. 42 U.S.C. § 12112(d)(4)(A) (2012).

271. *Patten*, 359 P.3d at 482.

272. *Id.* at 483; *King v. Burwell*, 135 S. Ct. 2480 (2015).

273. *Patten*, 359 P.3d at 474.

274. *Id.*

275. *Id.*

276. *Id.* at 476. Plaintiffs also claimed unsuccessfully that the defendants violated their Fourth Amendment rights to be free from unreasonable search and seizure. This Article does not analyze that claim because it has more limited relevance to private employers and business law scholars in general.

277. *Id.*

278. *Id.* at 478.

279. *Id.* at 480.



court's view. "The conversion companies, the insurers and the health-care providers are all subject to the stringent security protections required by HIPAA," it reasoned.<sup>280</sup> The fact that "wrongful disclosure of individually identifiable health information by a person in a HIPAA covered entity is a crime, punishable by a fine of up to \$50,000, a prison term of up to one year, or both" was "significant."<sup>281</sup> Missing from the court's analysis was the acknowledgment that the plaintiffs could not bring a claim under HIPAA against their employers because HIPAA offers no private right of action.<sup>282</sup>

*b. Watterson v. Garfield Beach CVS*

In a case decided a month before *Van Patten*, the United States District Court for the Northern District of California ruled that financial incentives attached to an employer wellness program did not render participation in that program involuntary.<sup>283</sup> *Watterson v. Garfield Beach CVS* concerned Roberta Watterson, a drugstore employee, who enrolled in a group medical insurance plan offered by her employer.<sup>284</sup> A few years after she enrolled, the plan instituted a requirement that all members complete an annual health screening and online wellness review.<sup>285</sup> Watterson claimed that she should have been compensated for her time spent completing the plan's required screenings and online reviews.<sup>286</sup> California law provides that employees must be paid while they are "subject to the control" of their employers.<sup>287</sup> Watterson argued that she was "subject to the control" of her employers while completing the wellness program requirements.<sup>288</sup>

The court rejected Watterson's claim because, it noted, there was "no dispute that Plaintiff voluntarily enrolled in the Plan, which is offered as part of Defendant's optional benefit package for employees."<sup>289</sup> In passing, the court appeared to acknowledge that the wellness program itself might not be voluntary for plan participants, but did not address the subject specifically. It noted that the present case

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280. *Id.*

281. *Id.* at 478–79.

282. *Id.* at 476.

283. *Watterson v. Garfield Beach CVS LLC*, 120 F. Supp. 3d 1003 (N.D. Cal. 2015).

284. *Id.* at 1004.

285. *Id.* at 1005.

286. *Id.*

287. *See, e.g.,* INDUS. WELFARE COMM'N, OFFICIAL NOTICE: ORDER NO. 7-2001 REGULATING WAGES, HOURS AND WORKING CONDITIONS IN THE MERCANTILE INDUSTRY (July 1, 2014), <https://www.dir.ca.gov/IWC/IWCArticle7.pdf>.

288. *Watterson*, 120 F. Supp. 3d at 1006.

289. *Id.*

involved “an optional benefit with strings attached.”<sup>290</sup> The “strings attached” language suggests a recognition that a financial incentive such as the one in *Watterson* may render at least the wellness program element of health care involuntary. A key point for the court, however, was whether *Watterson*’s enrollment in the insurance plan itself was voluntary.<sup>291</sup> Because that plan was a “purely optional benefit,” *Watterson* could not demonstrate that she was “subject to the control” of her employer while completing the program requirements, and therefore was ineligible for compensation for that time.<sup>292</sup>

Although the *Watterson* court was not interpreting the voluntariness of the wellness program exception under the ADA, its determination that a health insurance plan was optional underscores a presumption that employees are free to choose whether to secure health insurance from their employer or from another source. As a result, a CVS employee was left with the choice of whether to spend thousands of dollars privately funding her health insurance or take part in a wellness program that required her to provide confidential health information.<sup>293</sup>

*Van Patten* and *Watterson*, like *Seff* and *Flambeau*, expand the powers of employers to compel employee participation in wellness programs by finding various ways around the ADA’s general prohibition on unnecessary workplace health inquiries. Presumably, *Orion* and *Honeywell* will do the same if they are not settled out of court first. Together with the EEOC’s expansion of the permissible incentives associated with workplace wellness programs, these decisions effectively increase employers’ ability to pressure employees into providing health information through wellness programs or face often significant financial consequences.

*B. Judicial Interpretations of Anti-Discrimination Provisions  
Subvert Their Original Intent and Risk Seriously  
Harming Employees*

Using the insurance safe harbor language to protect employers in the manner adopted by *Seff*, and more recently by *Flambeau*, undermines Congress’ intent in passing the ADA as reflected in its legislative history.

The legislative history of the ADA sheds some light on the origins of the insurance safe harbor. It demonstrates that Congress did

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290. *Id.* at 1008.

291. *Id.* at 1006.

292. *Id.* at 1008.

293. *See id. passim.*

not mean to facilitate a process through which an employer could restrict health insurance eligibility when an employee refuses to complete a health assessment that could reveal disability-related information.

The Committee on Education and Labor recognized the risk that wellness programs might be misused as a means of restricting access to health insurance, and made it clear that doing so would violate the ADA. As early as 1990, it observed the trend that “a growing number of employers today are offering voluntary wellness programs in the workplace,” including “medical screening for high blood pressure, weight control, cancer detection, and the like.”<sup>294</sup> It then noted that these were acceptable under the ADA insofar as they did not restrict access to health insurance:<sup>295</sup> “As long as the programs are voluntary and the medical records are maintained in a confidential manner and *not used for the purpose of limiting health insurance eligibility* or of preventing occupational advancement, these activities would fall within the purview of accepted activities.”<sup>296</sup>

It is possible that the Committee intended to decry using the results of the wellness program tests, and not the programs *per se*, as a barrier to health insurance access. In another passage, for example, it noted that “medical examinations of employees may be permitted, provided the results of those examinations are not used to limit an employer’s eligibility for employer-provided health insurance.”<sup>297</sup>

The insurance safe harbor of the ADA has an important and often overlooked caveat. While Section 12201 specifies that the ADA does not restrict a covered entity from “establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks . . . classifying risks,” it goes on to caution that that provision “shall not be used as a subterfuge to evade the purposes of Subchapter I and III of this chapter.”<sup>298</sup> Subchapter I prohibits employment discrimination on the basis of disability.<sup>299</sup> Subchapter III prohibits discrimination on the basis of disability in public accommodations and transportation services operated by private entities.<sup>300</sup> The purpose of the ADA on the whole, however, is:

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294. H.R. REP. NO. 101-485, at 75 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 357.

295. *Id.*

296. *Id.* (emphasis added).

297. *Id.*

298. Americans with Disabilities Act (ADA), 42 U.S.C.A. § 12201(c) (West 2016).

299. *Id.* § 12112.

300. *Id.* §§ 12182(a), 12184(a).

- (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
- (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
- (3) to ensure that the Federal Government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and
- (4) to invoke the sweep of congressional authority, including the power to enforce the Fourteenth Amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.<sup>301</sup>

In sum, the purpose of the ADA is to provide a mandate for eliminating disability discrimination and to protect people with disabilities from discrimination. It would be inconsistent with those purposes to interpret the insurance safe harbor provision in a manner that reinforces the ability of employers to cut off health insurance to employees who refuse to comply with wellness programs that might reveal, to their potential detriment, their own disability-related health information.

The Committee's notes on the adoption of the insurance safe harbor language underscore an important caveat. The Committee warned that "while a plan which limits certain kinds of coverage based on classification of risk would be allowed under this section, the plan may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual . . . except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience."<sup>302</sup> Denying insurance eligibility on the basis of refusal to comply with the terms of a wellness program arguably effects this kind of refusal.

## V.

### LEGISLATORS AND EMPLOYERS SHOULD RECONSIDER THE EXPANSION OF WELLNESS PROGRAMS

The social costs and inefficiencies of wellness programs described in Part II of this Article, in light of the disjointed evolution of wellness programs described in Parts III and IV, suggest that certain changes to the regulation of wellness programs would result in a net social benefit. In light of these concerns, federal regulators should re-

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301. *Id.* § 12101(b).

302. H.R. REP. NO. 101-485, at 136 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 419-20.

consider the extent to which employers should be permitted to collect health information through wellness programs, especially those with incentives and/or penalties attached.

*A. Voluntariness Should Be Measured by Income, Not Coverage*

A first potential solution would be to amend the ACA, as well as the relevant interpretive guidance for the ADA and GINA, to reframe the definition of a “voluntary” health plan. What makes a wellness program incentive “significant” should be determined with respect to an employee’s livelihood overall, rather than as a percentage of the employee’s health coverage costs.

The extent to which a wellness program incentive burdens an employee, and is therefore “voluntary,” depends on the financial impact it has. An incentive is, viewed from a slightly different angle, a cost. The Departments of Labor, Health and Human Services, and the Treasury recognized this in their introduction of the 2013 amendments increasing the level of permissible incentives in wellness plans: “Rewards also could create costs to individuals and to the extent the new larger rewards create more costs than smaller rewards, these final regulations may increase the costs relative to the 2006 regulations,” they cautioned.<sup>303</sup> “To the extent an individual does not meet a standard or satisfy a reasonable alternative standard, they could face higher costs.”<sup>304</sup>

A more just measure of incentives would look at the financial impact of the incentive on the individual employee. As health insurance costs rise, they may constitute an increasing financial burden on employees. Rising health insurance costs arguably affect employers’ decisions to impose workplace wellness programs in the first place.

Rather than comparing the cost of the incentive to the cost of the overall coverage, regulators instead might compare the cost of the incentive to the employee’s net income. The EEOC already uses net income as the basis for determining whether health insurance overall is affordable. Federal law determines that the cost of health insurance is considered “affordable” if the employee’s cost does not exceed a certain percentage of household income (9.5% in 2015).<sup>305</sup>

The EEOC has expressed some concern about the impact of wellness program incentives on lower-income employees, and now ap-

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303. See Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,157, 33,159 (June 3, 2013).

304. *Id.*

305. 26 U.S.C. § 36B(c)(2)(C) (2012).

pears to be considering whether to measure the impact of wellness program incentives in terms of overall affordability. In the NPRM on the ADA issued in April 2015, the EEOC sought public input on whether it should prohibit employers from using incentives that would render the health care program unaffordable under federal law.<sup>306</sup> Specifically, it asked whether “to be considered ‘voluntary’ under the ADA, the incentives provided in a wellness program that asks employees to respond to disability-related inquiries and/or undergo medical examinations may not be so large as to render health insurance coverage unaffordable under the Affordable Care Act and therefore in effect coercive for an employee.”<sup>307</sup>

The most persuasive argument against using net income, rather than the cost of insurance, as the better standard against which to measure the impact of a wellness program incentive may be the additional administrative burden of such a measuring requirement. Whether the EEOC decides to adopt a more direct approach to measuring the affordability of wellness program incentives remains to be seen, presumably when it announces its final Rule on Incentives for Nondiscriminatory Wellness Programs in Group Health Plans.

*B. HIPAA Should Be Amended to Provide Greater Control over Employee Test Results*

The way privacy laws are written has an impact on the likelihood of employees to agree to the kind of testing that wellness programs increasingly require. For example, a recent study of state genetic privacy laws revealed that how a privacy law is structured has a measurable effect on the likelihood of users to get genetic tests in the first place.<sup>308</sup> States take one of three approaches to regulating genetic privacy. In seventeen states, the laws require informed consent for a third party to obtain genetic information.<sup>309</sup> In twenty-seven states, the laws give individuals explicit ownership rights over their data.<sup>310</sup> Additionally, many states have anti-discrimination laws that prohibit the discriminatory use of genetic data.<sup>311</sup> According to the study, state laws which give users control over disclosure of their test results encourage genetic testing, while state laws which require informed consent deter

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306. Amendments to Regulations Under the Americans with Disabilities Act, 80 Fed. Reg. 21,664 (Apr. 20, 2015).

307. *Id.*

308. Miller & Tucker, *supra* note 55, at 3.

309. *Id.*

310. *Id.*

311. *Id.*

users from getting genetic tests.<sup>312</sup> In other words, state laws that limit unauthorized disclosure of test results correlate with an increase in the number of people seeking genetic tests in those states.

The third type of laws, those which explicitly prohibit discrimination based on the use of genetic data, had no effect on the likelihood of user testing.<sup>313</sup> The authors do not offer a conclusion as to why anti-discrimination laws had less of an effect, positively or negatively, on the incidence of testing, but they note that there are a few possible explanations. One is that “consumers are already able to effectively protect the privacy of their genetic test results from employers or insurers by paying out of pocket for testing.”<sup>314</sup> This posits that anti-discrimination laws have no impact on individuals they cannot protect, since private test results presumably never reach the employer or insurer who might illegally discriminate.<sup>315</sup> Another theory is that “[a]nti-discrimination rules may increase the willingness of consumers to undergo testing while at the same time decrease the willingness of health insurers (or employers in the case of employment-based self-insured health plans) to cover the tests.”<sup>316</sup>

In light of these results, Congress should consider amending HIPAA to provide employees with greater control over the data collected by workplace wellness programs. The likely benefits include more personal data security as well as an increased number of employees who are genuinely willing to provide the kind of health data that the Precision Medicine Initiative is designed to help collect.

#### CONCLUSION

While advocates of workplace wellness programs may see the increased ability to compel employee participation as a social benefit resulting in a healthier workforce, the literal and figurative costs to employees who do not comply with the intrusive terms of those programs are mounting. As workplace wellness programs expand in scope, employees are losing a meaningful choice as to whether to take part in them. Employees face financial penalties if they do not do so, in the form of lost health insurance coverage and/or foregone financial incentives for participating in workplace wellness programs. These financial penalties do not render a program “involuntary” and therefore in potential violation of the ADA unless and until they reach 30% of

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312. *Id.*

313. *Id.* at 9.

314. *Id.* at 3.

315. *Id.*

316. *Id.* at 13.

the cost of the plan, regardless of the employee's base salary or net income. Even if the costs exceed this newly increased limit, employers are increasingly likely to succeed on the argument that their wellness plans fall under the ADA's insurance safe harbor, in spite of evidence that Congress never intended to permit an interpretation of that safe harbor that would subvert the anti-discrimination purposes of the ADA.

In addition, workplace wellness programs have other significant flaws. The risks of re-identification through sensor fusion and unauthorized interception of health data underscore these shortcomings. These risks include the provision of inaccurate information through employee misuse or device inaccuracy, the interception of sensitive health data by hackers, and the increased stigmatization of overweight people who do not meet the statutory definition of "disabled" under the ADA. Current federal laws do too little to protect employees from adverse actions based on the data they provide through wellness programs.

This Article assumes that most employers intend to comply with all applicable federal laws, including the mandate of the ADA and GINA to prohibit discrimination on the basis of disability or health information. The lure of workplace wellness programs, incentivized by the ACA and intended to help offset the increasing cost of health insurance, exacerbated in many cases by the impending Cadillac tax, may be inescapable. Both case law and federal regulations are converging to increase the scope of workplace wellness programs, especially those that penalize noncompliance. Although employers have a strong financial interest in their employees' good health, they should reconsider the expansion of incentive-based wellness programs in the workplace because of the significant legal risks those programs create.

The social injustice, larger costs, inefficiencies and privacy risks inherent in workplace wellness programs should cause employers at least to question the overall benefits of such an expansion, and should cause legislators to create more robust protections for employees from incentive-based wellness programs.