

MORE CARROT, LESS STICK: WORKPLACE WELLNESS PROGRAMS & THE DISCRIMINATORY IMPACT OF FINANCIAL AND HEALTH-BASED INCENTIVES

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Abstract: In recent years, more and more employers are turning to workplace wellness programs to combat rising health care costs by rewarding employees for improving their health-related behaviors and penalizing those who do not attain measureable health outcomes. Yet these wellness programs run counter to the goals of improving the overall health and livelihood of employees when they shift health care costs onto the employees who need lower premiums the most. There is little evidence that these programs can avoid being discriminatory. This Note analyzes the disparate impact of workplace wellness programs on low-income individuals, individuals with disabilities, and certain racial minorities. It explains how employers utilize wellness programs as a subterfuge for discriminatory cost-shifting—in violation of the Americans with Disabilities Act and Title VII of the Civil Rights Act of 1964—that decreases access to, and affordability of, quality health care services. This Note argues that, in order to rectify the discriminatory effects of these programs, the Equal Employment Opportunity Commission must issue explicit guidance and exercise its power effectively as an enforcer of anti-discrimination law. Additionally, the Health Insurance Portability and Accountability Act must be modified to better define “voluntariness” within the realm of incentives and penalties.

INTRODUCTION

Dale Arnold, an employee of Flambeau, Inc. (“Flambeau”), a Wisconsin-based manufacturer and distributor of industrial, commercial, and consumer plastic, went on medical leave in 2011 for treatment of his cardiomyopathy and congestive heart failure.¹ In December 2011, while Arnold was on leave, Flambeau asked its employees to complete biometric testing and health risk

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¹ Complaint at 2, 3–4, Equal Employment Opportunity Comm’n v. Flambeau, Inc., Docket No. 3:14-cv-00638 (W.D. Wis. 2014) [hereinafter EEOC Complaint against Flambeau]. Cardiomyopathy is a heart muscle disease that can disrupt normal cardiac function. Liana Daley et al., *A Patient’s Journey: Cardiomyopathy*, 340 BRIT. MED. J. 808, 809 (2010).

assessments as part of the company's wellness program.² The biometric testing collected blood work and various body measurements.³ The health assessment asked each worker to disclose his or her medical history and answer disability-related questions.⁴ Upon returning from his medical leave, Arnold attempted to complete both the health assessment and biometric testing.⁵ The allotted time to fulfill the requirements as determined by Flambeau, however, had passed, and Arnold's requests to complete the testing were subsequently rejected.⁶

Under Flambeau's wellness plan, employees who completed the assessment and testing during the designated time frame were only required to pay twenty-five percent of their health insurance premium.⁷ If an employee failed to meet these requirements, he or she would be penalized by being required to pay the entire premium for his or her health insurance coverage.⁸ Because Arnold did not fulfill the program requirements—due to his medical-related absence—Flambeau shifted the entire cost of the premium onto him.⁹ Arnold was unable to afford this penalty, and his coverage was subsequently terminated on January 6, 2012.¹⁰ Arnold then alerted the Equal Employment Opportunity Commission (EEOC) of the termination.¹¹ In 2014, the EEOC filed a lawsuit against Flambeau alleging that the health risk evaluation and biometric testing requirements violated the Americans with Disabilities Act (ADA), which prohibits disability discrimination in employment, including requiring disability-related disclosures.¹²

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In 2014, Honeywell International Inc. ("Honeywell"), an international manufacturer of engineering and aerospace systems and commercial and con-

² EEOC Complaint against Flambeau, *supra* note 1, at 3–4.

³ *Id.* at 3.

⁴ *Id.*

⁵ *Id.* at 4.

⁶ *Id.* at 4. ("Arnold was subjected to termination of his health insurance and a financial penalty of having to pay the entire premium cost . . . as a result of not completing the examinations and inquiries . . . because Flambeau told Arnold . . . that failing to attend the testing at [his] scheduled time would result in 'disciplinary action'").

⁷ *See id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *See* EEOC Complaint against Flambeau, *supra* note 1, at 2.

¹² *Id.* at 4. The EEOC's complaint contended that Flambeau's requirements were not "voluntary" under the specifications required by the ADA because the penalty for noncompliance was so significant, and that the health risk assessment and biometric testing were not job-related or consistent with business necessity. *Id.* at 5.

sumer products, asked its employees to participate in a wellness program.¹³ Under the program's provisions, on a voluntary basis, employees and their spouses were screened for cholesterol, blood pressure, body-mass index, blood-sugar levels, waist circumference, and nicotine.¹⁴ Honeywell offered employees who chose to undergo testing between \$250 and \$1500 credited to their health savings accounts.¹⁵ Employees who decided not to undergo testing faced several penalties, including an additional \$500 payment for health insurance and a \$1000 surcharge based on the presumption that they use tobacco.¹⁶ If a married employee's spouse was covered by Honeywell's insurance and refused to sit for the screening, the employee received an additional \$1000 tobacco surcharge.¹⁷

Honeywell claims that its corporate wellness program serves dual purposes: to inform employees about their health status in an effort to support their overall wellbeing and to prevent healthy employees from subsidizing healthcare premiums for less healthy employees.¹⁸ The program works by collecting the cumulative data of participants.¹⁹ The employer then creates initiatives designed to combat diseases prevalent among participants that contribute to rising healthcare costs, such as obesity and high blood pressure.²⁰

The sizable amount of money that Honeywell charges employees for non-compliance, however, caught the attention of federal regulators.²¹ In October 2014, the EEOC filed a lawsuit against Honeywell in the U.S. District Court in Minneapolis arguing that the program violates the ADA and the Genetic Information Nondiscrimination Act ("GINA").²²

¹³ See Lauren Weber, *Wellness Program at Honeywell Faces Test*, WALL ST. J. (Oct. 29, 2014, 7:43 PM), <http://online.wsj.com/articles/wellness-program-at-honeywell-faces-test-1414626180> [perma.cc/29E2-36UY].

¹⁴ *Id.*; Len Boselovic, *Workzone: EEOC Disapproves of Incentives for Honeywell Program*, PITTSBURGH POST-GAZETTE (Nov. 9, 2014, 12:00 AM), <http://www.post-gazette.com/business/2014/11/09/Workzone-EEOC-disapproves-of-incentives-for-Honeywell-program/stories/201411090011> [perma.cc/RU35-3QR4].

¹⁵ Boselovic, *supra* note 14.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ See Press Release, Honeywell, Honeywell Responds to EEOC's Frivolous Lawsuit to Stop Company's Biometric Screening for Employees (Oct. 29, 2014), <https://honeywell.com/News/Pages/Honeywell-Responds-to-EEOCs-Frivolous-Lawsuit-To-Stop-Companys-Biometric-Screening-for-Employees.aspx> [perma.cc/3BKU-8ZY5].

¹⁹ See Boselovic, *supra* note 14.

²⁰ *Id.*

²¹ Weber, *supra* note 13.

²² EEOC v. Honeywell Int'l Inc., 2014 WL 5795481, at *2 (D. Minn. 2014). The Genetic Information Nondiscrimination Act of 2008 prohibits employer discrimination based on genetic information and limits employer access to the genetic information of its employees. 42 U.S.C. § 300gg-53 (2014).

Both Flambeau's and Honeywell's programs are part of a growing trend of workplace wellness initiatives designed to improve employee health and to control the cost of healthcare.²³ Many employers attempt to boost their wellness programs by setting higher health standards and rewarding employees for healthy behavior.²⁴ However, as the cost of healthcare and insurance continues to escalate, more employers are starting to penalize noncompliant employees or employees with unhealthy lifestyles in an effort to avoid covering the cost of expensive premiums.²⁵

As policies imposing financial penalties on employees become the norm, companies have defended their decisions to implement these cost-shifting approaches.²⁶ Some employers highlight the high healthcare costs of treating preventable diseases such as cardiovascular disease, diabetes, and obesity as justification.²⁷ Others see incentives and penalties as a way of coaxing workers to take personal responsibility for, and better care of, their wellbeing.²⁸ But if an employee chooses not to participate in a punitive wellness program or cannot meet the benchmarks established by the employer, he or she is vulnerable to higher premiums and surcharges.²⁹

In addition to cost-shifting, another danger lies in the fact that employer programs may have a disparate impact on low-wage workers.³⁰ If the penalties are set too high, employees who cannot afford to opt out may have no choice but to participate, effectively rendering the program mandatory.³¹ Additionally, many individuals and populations are environmentally, socioeconomically, or

²³ Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359;2 NEW ENG. J. MED. 192, 192 (2008).

²⁴ Weber, *supra* note 13.

²⁵ *Id.*; Robert Glatter, *Corporate Wellness Programs: The Carrot or the Stick?*, FORBES (Mar. 11, 2014), <http://www.forbes.com/sites/robertglatter/2012/03/11/corporate-wellness-programs-the-carrot-or-the-stick/> [perma.cc/7JHA-Z67V].

²⁶ See Stephen A. Burd, *How Safeway Is Cutting Health-Care Costs*, WALL ST. J. (June 12, 2009), <http://online.wsj.com/news/articles/SB124476804026308603>. (“While comprehensive health-care reform needs to address a number of other key issues, [Safeway believes] that personal responsibility and financial incentives are the path to a healthier America.”); Laura Anderko et al., *Promoting Prevention Through the Affordable Care Act: Workplace Wellness*, CTR. FOR DISEASE CONTROL AND PREVENTION (Dec. 13, 2012), http://www.cdc.gov/pcd/issues/2012/12_0092.htm [perma.cc/64YA-RF5G].

²⁷ See Anderko et al., *supra* note 26; Glatter, *supra* note 25.

²⁸ See Glatter, *supra* note 25; see also Burd, *supra* note 26 (comparing personal responsibility in healthcare to the role personal responsibility plays in the automobile industry when establishing higher premiums).

²⁹ See Glatter, *supra* note 25.

³⁰ Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571, 629 (2014).

³¹ See Reed Abelson, *The Smoker's Surcharge*, N.Y. TIMES (Nov. 16, 2011), <http://www.nytimes.com/2011/11/17/health/policy/smokers-penalized-with-health-insurance-premiums.html> [perma.cc/6PSX-5AHN].

genetically tied to their health statuses.³² Low-income individuals, for instance, have limited access to healthy, affordable foods; employer-based health benchmarks may be unattainable because of socioeconomic obstacles.³³ Additionally, some racial minorities are more likely to have chronic diseases, such as obesity and heart disease, and are therefore more likely to pay higher premiums.³⁴ Corporate wellness programs that use punitive strategies to coerce workers to achieve health benchmarks disproportionately shift costs onto populations that are more likely to experience significant health disparities.³⁵

This Note explores the disparate impact that employer wellness programs offering incentives for participation impose upon low-income individuals, racial minorities, and individuals with disabilities. Part I of this Note examines the recent increase in popularity of employer wellness programs. It argues that the Affordable Care Act (ACA), combined with rising healthcare costs, are encouraging employers to shift the cost of health insurance onto their employees. Part II first outlines the disputed benefits of corporate wellness programs. It further illustrates how these possible benefits are outweighed by their potential legal ramifications, focusing on the legal parameters of the ADA and Title VII. This section argues that workplace wellness programs run afoul of federal anti-discrimination laws by placing low-income individuals, racial minorities, and individuals with disabilities at significant financial and health-related disadvantages. Finally, Part III calls for several possible solutions to discriminatory workplace wellness programs, including a requirement that the EEOC issue clear and specific guidance regarding the framework for lawful programs, a recommendation that the EEOC pursue novel and significant legal cases to better enforce non-discriminatory laws in the workplace, and an amendment to the Health Insurance Portability and Accountability Act (HIPAA).

I. JUMPING ON THE BANDWAGON OF EMPLOYER WELLNESS PROGRAMS

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law.³⁶ Enacted to increase the affordability and accessibility of healthcare coverage nationwide, the ACA introduced signifi-

³² Roberts, *supra* note 30, at 626.

³³ *See id.*

³⁴ *See* Written Testimony of Judith Lichtman, Senior Advisor, Nat'l Partnership for Women & Families, U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM'N (May 8, 2013), <http://www1.eeoc.gov/eeoc/meetings/5-8-13/lichtman.cfm> [perma.cc/2XLB-97Q4] [hereinafter Written Testimony of Judith Lichtman].

³⁵ *Id.*

³⁶ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010); *see* Edie Lindsey, Using Incentives in Workplace Wellness Programs: The Impact of Federal Employment Discrimination Laws 2 (May 17, 2013) (unpublished masters thesis, Georgia State University), http://scholarworks.gsu.edu/cgi/viewcontent.cgi?article=1286&context=iph_theses [perma.cc/4327-Z7UZ].

cant changes to the nation's healthcare system.³⁷ The ACA was designed to achieve a number of ambitious goals, including increasing the availability of health coverage for Americans—especially those with preexisting conditions—expanding options for purchasing affordable coverage, and improving the overall quality of healthcare and medical services.³⁸ Notably, the ACA also encourages employers to adopt wellness programs for employees.³⁹ In an effort to leverage the workplace to affect healthy changes among employees, the ACA supports employer-based programs that screen for health risks and provide information and interventions to promote healthier lifestyles.⁴⁰

On June 3, 2013, the U.S. Departments of Treasury, Labor, and Health and Human Services built upon foundations established in the ACA and finalized new workplace wellness program regulations.⁴¹ The purpose of these new regulations, which went into effect on January 1, 2014, was to protect against discrimination in group health plans and increase the maximum reward available to compliant employees under health-contingent wellness programs.⁴² A natural result of these changes has been a greater emphasis on the role incentives and penalties play in corporate wellness programs to encourage healthier behavior among employees.⁴³

³⁷ See Lindsey, *supra* note 36, at 2.

³⁸ See 42 U.S.C. §§ 18001 et seq. (2010); *Strategic Goal 1: Strengthen Health Care*, U.S. DEP'T OF HEALTH AND HUMAN SERV. (Mar. 10, 2014), <http://www.hhs.gov/strategic-plan/goal1.html> [perma.cc/528L-S87U].

³⁹ Lindsey, *supra* note 36, at 2.

⁴⁰ See 42 U.S.C. § 2801 (2014). The statute explains that “to expand the utilization of evidence-based prevention and health promotion approaches in the workplace,” a Director must provide employers:

[W]ith technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including . . . (A) measuring the participation and methods to increase participation of employees in such programs; (B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and (C) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees

Id.

⁴¹ See *Incentives For Nondiscriminatory Wellness Programs in Group Health Plans*, 78 Fed. Reg. 33,158 (June 3, 2013).

⁴² *Id.*

⁴³ *Id.* at 33,171–72. The regulations explain: “In the Departments' impact analysis for the proposed rules, available data indicated that employers' use of incentives in wellness programs was relatively low.” *Id.* It further states, “To the extent larger rewards are more effective at improving health and lowering costs, these final regulations will produce more benefits than the current requirements.” *Id.*

A. The Rise of Employer Wellness Programs Due to the ACA and Rising Healthcare Costs

The evolution of the Health Insurance Portability and Accountability Act (HIPAA) provides important context for a better understanding of how incentive-based wellness programs have developed under the ACA in recent years.⁴⁴ In 2006, the then ten-year-old HIPAA was amended to include wellness provisions that complied with nondiscrimination requirements.⁴⁵ Under new provisions, employers were permitted to reward employees for participating in wellness programs that were directly related to a “health factor.”⁴⁶ The amended regulations further expounded that the amount of the reward offered for satisfying a health factor in a wellness program could not exceed twenty percent of the cost of employee-only coverage under the plan.⁴⁷ Simply put, employers were permitted to reduce the insurance premiums by twenty percent for employees who participated in wellness programs.⁴⁸

New ACA regulations built upon the regulations established in HIPAA and increased the maximum reward available to employers under health-contingent wellness programs.⁴⁹ Employers may now implement a premium reduction of thirty percent for participation in a health-contingent wellness program, which totals approximately \$1620 annually per employee.⁵⁰ Further, if an employer is offering a wellness program designed to prevent or reduce tobacco use, it may charge tobacco users up to fifty percent more in premiums

⁴⁴ See *id.* at 33,159. The ACA amended the HIPAA nondiscrimination and wellness provisions of the Public Health Service Act. *Id.*

⁴⁵ Nondiscrimination and Wellness Programs in Health Coverage in the Group Market: Final Rules, 71 Fed. Reg. 75,014–17 (Dec. 13, 2006). The amendments provide the final rules regulating the prohibition of discrimination based on a health factor for group health plans. *Id.*

⁴⁶ *Id.* at 75,018. Defining “health factor” as any of the following related to health status: health status, medical condition (including both physical and mental illness), claims experience, receipt of healthcare, genetic information, evidence of insurability, or disability. *Id.* at 75,030.

⁴⁷ *Id.* at 75,017.

⁴⁸ See *id.* The regulations also established several other mandatory requirements for wellness programs. *Id.* at 75,018. Each program had to be “reasonably designed” to promote healthy behavior or prevent disease and had to provide eligible individuals the opportunity to qualify for the reward at least once per year. *Id.* at 75,036. Any rewards or benefits had to apply uniformly to all similarly situated individuals. *Id.* Finally, reward-based wellness programs must have provided a reasonable alternative for obtaining the reward for individuals for whom “it is unreasonably difficult due to a medical condition to meet the otherwise applicable standard, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard.” Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158, 33,160 (June 3, 2013).

⁴⁹ See Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158 (June 3, 2013).

⁵⁰ See *id.*; Sharon Begley, *Exclusive: ‘Workplace Wellness’ Fails Bottom Line, Waistlines—RAND*, REUTERS (May 24, 2013, 6:39 PM), <http://www.reuters.com/article/2013/05/24/us-wellness-idUSBRE94N0XX20130524> [perma.cc/H5PH-XN47].

than nonusers.⁵¹ Both of these changes are intended to pave the way for employers to encourage plan participation.⁵²

The ACA provisions support two different types of wellness programs intended to improve employee health: “participatory wellness programs” and “health-contingent wellness programs.”⁵³ Participatory wellness programs are available regardless of an individual’s health status.⁵⁴ Examples include programs that reimburse employees for enrolling in fitness memberships or programs that reward employees for attending certain health-education seminars.⁵⁵ On the other hand, health-contingent wellness programs require participants to meet specific health-related benchmarks in order to obtain a reward.⁵⁶ An example of a health-contingent wellness program is one that provides a reward to individuals who do not use tobacco or who decrease their tobacco use.⁵⁷ Another example consistent with new ACA regulations is a program that implements biometric testing to screen for employees with certain medical conditions or health risks, such as screening for high cholesterol, high blood pressure, or a high body-mass index.⁵⁸ Once a condition or risk is identified, the

⁵¹ SOEREN MATTKE ET AL., RAND HEALTH, WORKPLACE WELLNESS PROGRAMS STUDY: FINAL REPORT, at xx (2013).

⁵² See *How the Affordable Care Act Will Impact Workplace Wellness Programs*, MM HAYES (JUNE 18, 2013, 10:40 AM), <http://www.mmhayes.com/how-the-affordable-care-act-will-impact-workplace-wellness-programs/> [perma.cc/VD4T-ZAV5]. The article provides an explanation of a health-contingent wellness program and reward:

Let’s say the total annual cost of an employee’s health insurance is \$5,000. \$2,500 was paid by the employer and \$2,500 paid by the employee. The enrolled employee could receive a \$1,500 reduction of their cost as a reward for having a total cholesterol level of less than 200 (30% reduction of \$5,000). The program could also reduce the employee’s premium by an additional \$1,000 if they had not used tobacco in the last year (add an additional 20% reduction of \$5,000). The employee could potentially eliminate their out of pocket expense for health insurance if they met the wellness program requirements from the rewards they would receive (50% reduction of \$5,000 = \$2,500).

Id.

⁵³ Incentives For Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,160–61 (June 3, 2013).

⁵⁴ *Id.* at 33,160.

⁵⁵ *Id.* at 33,160–61.

⁵⁶ *Id.* Health-contingent wellness programs are further divided into activity-only programs and outcome-based programs. *Id.* at 33,161. Activity-only programs require participants to complete an activity, such as diet or exercise programs, in order to obtain a reward. *Id.* Outcome-based programs require a participant to reach a specific health outcome goal or factor, such as quitting smoking or lowering one’s body-mass index. *Id.* Generally, outcome-based programs ask participants to submit to testing or screening. *Id.* Individuals who meet certain health factor benchmarks are offered a reward, while individuals who fail to meet the standard are required to participate in additional program requirements until the standard is met in order to obtain the reward. *Id.*

⁵⁷ See *id.* at 33,161.

⁵⁸ *Id.*

program can then require the employee to take steps to lower these numbers or meet a specific health benchmark to obtain the reward.⁵⁹

The definition of reward under ACA regulations is also significant.⁶⁰ Rewards include both positive benefits, such as discounts or rebates, *and* penalties, such as surcharges or financial disincentives.⁶¹ The ACA prohibits employment-related group health plans and insurers from discriminating against an individual on the basis of his or her health status.⁶² However, incentive-based wellness programs that hand out rewards and penalties are authorized as an exception.⁶³ If a wellness program meets certain requirements, it may implement incentives, discounts, surcharges, and penalties without running the risk of violating the ACA.⁶⁴ Despite their legality, these programs disparately impact low-wage employees who cannot afford to opt out of a program in which they may not want to participate.⁶⁵ They also adversely affect individuals with disabilities or chronic illnesses and certain racial minorities who are more vulnerable to health disparities.⁶⁶ These populations, already wracked with medical expenses, can feel coerced to participate in wellness programs to lower their overall healthcare costs.⁶⁷ They also are less able to attain employer-designated health benchmarks because of inherent health disparities and can unjustly face penalties for failing to meet the criteria.⁶⁸

⁵⁹ *Id.*

⁶⁰ *Id.* at 33,160.

⁶¹ *See id.*

⁶² Timothy Jost, *Implementing Health Reform: Workplace Wellness Programs*, HEALTH AFFAIRS BLOG (May 29, 2013), <http://healthaffairs.org/blog/2013/05/29/implementing-health-reform-workplace-wellness-programs/> [perma.cc/HYK7-NJN].

⁶³ *Id.*

⁶⁴ *Id.* The ACA adopts the same requirements as the 2006 amendments to the HIPAA. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,159 (June 3, 2013). Participatory wellness programs are not required to meet the following requirements, but health-contingent wellness programs must. *Id.* These requirements are:

- (i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan;
- (ii) The program must be reasonably designed to promote health or prevent disease;
- (iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year;
- (iv) The reward under the program must be available to all similarly situated individuals;
- (v) The plan must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard.

See T.D. 9298, 2007-1 C.B. 458.

⁶⁵ *See* Roberts, *supra* note 30, at 626.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *See* Written Testimony of Judith Lichtman, *supra* note 34.

Despite the possibility of negatively affecting low-wage and minority populations, with the aforementioned support from the ACA, employers are eagerly adopting wellness programs as a means of reducing health insurance costs.⁶⁹ Employer-based wellness is a six billion dollar industry in the United States with more than five hundred vendors selling wellness programs.⁷⁰ Nationally, approximately fifty-one percent of employers with fifty or more employees offer a wellness program.⁷¹ Sixty-nine percent of employers with fifty or more employees use financial incentives within their wellness programs to encourage employee participation.⁷²

The ACA's endorsement is not the only driving force behind the adoption of incentive-based wellness programs.⁷³ Rising healthcare costs are pressuring employers to shift the cost of health insurance onto their employees.⁷⁴ For instance, in 2006, sixteen percent of employees in small firms—companies with three to 199 workers—were enrolled in a health insurance plan with an annual deductible of \$1000 or more.⁷⁵ The figure rose to fifty percent in 2011 and to sixty-one percent in 2014.⁷⁶ In the last decade, premiums for small firms have increased by almost sixty-three percent, from \$9737 in 2004 to \$15,849 in 2014.⁷⁷ For large firms, companies with 200 or more workers, premiums have increased seventy-two percent, from \$10,046 in 2004 to \$17,265 in 2014.⁷⁸ These statistics reveal a concerning long-term pattern.⁷⁹ As premiums continue to hike, employers are shifting to plans that pressure employees to pay more out-of-pocket expenses.⁸⁰

B. Health-Contingent Wellness Programs: Walking a Fine Legal Line

Health-contingent wellness programs bring up several legal concerns.⁸¹ The first is their disparate impact on the most vulnerable populations of em-

⁶⁹ See Glatter, *supra* note 25.

⁷⁰ Begley, *supra* note 50.

⁷¹ MATTHEW ET AL., *supra* note 51, at 18.

⁷² *Id.* at xx.

⁷³ See Theo Francis, *Companies Prepare to Pass More Health Costs to Workers*, WALL ST. J. (Nov. 24, 2013, 9:36 PM), <http://online.wsj.com/articles/SB10001424052702304607104579212351200702342> [perma.cc/SU69-4MHS].

⁷⁴ *Id.*

⁷⁵ See KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2014 ANNUAL SURVEY 138 (2014).

⁷⁶ *See id.*

⁷⁷ *See id.* at 28.

⁷⁸ *See id.*

⁷⁹ *Id.*

⁸⁰ *See id.*; N.C. Aizenman, *Surveys: Health Insurance Costs Shifted to Workers, Even as Premiums Surge*, WASH. POST (Sept. 27, 2011), http://www.washingtonpost.com/national/health-science/survey-rising-health-insurance-costs-shifted-to-workers/2011/09/26/gIQA5SpX1K_story.html [perma.cc/9K4L-PEGR].

⁸¹ *See* Written Testimony of Judith Lichtman, *supra* note 34.

ployees.⁸² Health-contingent wellness programs use financial incentives to reward healthy individuals and to penalize unhealthy individuals.⁸³ As a result, the more vulnerable employees—those with health risks and those with socioeconomic barriers to good health—bear greater costs for healthcare.⁸⁴ These populations face greater challenges reaching health factors and benchmarks established by employers.⁸⁵ Incentive-based wellness programs, therefore, trigger federal laws due to this unjust impact on sicker and lower-income individuals.⁸⁶

Under the Americans with Disabilities Act (ADA), discrimination occurs when an employer treats an applicant or employee less favorably on the basis of a disability, such as cancer, or because of a physical or mental impairment.⁸⁷ The ADA prohibits an employer from inquiring into an employee's disability and from requesting that an employee undergo medical examinations, unless it is "job-related and consistent with business necessity."⁸⁸ Health-contingent wellness programs walk a fine line under the ADA when they probe into an employee's disability history, for instance, or penalize an employee who cannot participate in the program due to his or her disability.⁸⁹

Among other federal laws, employer wellness programs may also run afoul of Title VII of the Civil Rights Act of 1964 (Title VII).⁹⁰ Title VII bans discrimination against an individual with respect to his or her "compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin . . ."⁹¹ Punitive wellness programs generally violate Title VII if they treat a protected class of people, such as a racial minority, less favorably than others.⁹²

⁸² See *id.*

⁸³ See *id.*

⁸⁴ Jill R. Horwitz, Brenna Kelly, & John DiNardo, *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFFAIRS 468, 474 (2013). One report found positive associations between obesity and medical spending annually and high glucose or high cholesterol levels and medical spending annually. *Id.* at 471. Studies have shown that obesity can increase medical spending to more than \$1000 per individual, and even \$2000 per individual for those with very high body mass indices. *Id.* High cholesterol levels have been shown to increase medical spending by \$2500 per individual and high glucose can increase spending annually by \$3300 per individual. *Id.*

⁸⁵ See Written Testimony of Judith Lichtman, *supra* note 34.

⁸⁶ See *id.*

⁸⁷ See 42 U.S.C. § 12101 (2012). The ADA defines a "disability" as a physical or mental impairment that substantially limits one or more major life activities of such individual. See 42 U.S.C. § 12102.

⁸⁸ See *id.* § 12112.

⁸⁹ See Written Testimony of Judith Lichtman, *supra* note 34.

⁹⁰ 42 U.S.C. § 2000a (2012); Written Testimony of Judith Lichtman, *supra* note 34.

⁹¹ 42 U.S.C. § 2000e-2(a)(1) (2014).

⁹² See Written Testimony of Judith Lichtman, *supra* note 34.

Despite these concerns, lawsuits asserting that health-contingent wellness programs violate federal law have not made much progress towards lessening the disparate impact on these vulnerable populations.⁹³ In 2012, in *Seff v. Broward County*, the U.S. Court of Appeals for the Eleventh Circuit held that a wellness program in Florida's Broward County did not violate the ADA.⁹⁴ In *Seff*, the wellness program consisted of biometric screening, requiring employees to participate in a blood test to identify any of the following conditions: asthma, hypertension, diabetes, congestive heart failure, or kidney disease.⁹⁵ Employees afflicted with one of the conditions were asked to enroll in a disease management course and were offered co-pay waivers for certain medications in exchange for their attendance.⁹⁶ The employer further encouraged participation by imposing a twenty-dollar deduction from each paycheck for employees who refused to participate in the program.⁹⁷ Bradley Seff, the plaintiff, filed a suit against the employer claiming that the ADA prohibited such non-voluntary examinations and disability-related inquiries.⁹⁸ The Eleventh Circuit rejected this argument and held that the program fell under the ADA's "bona fide plan" exception.⁹⁹ The court interpreted the wellness program to be a "term"—not a stand-alone program—under the county's health insurance plan and, therefore, it fell under the ADA's safe harbor provision.¹⁰⁰

Recently, in November 2014, the District Court of Minnesota ruled in favor of Honeywell International Inc. ("Honeywell") in the lawsuit that the Equal Employment Opportunity Commission (EEOC) brought against the company, discussed in the Introduction of this Note.¹⁰¹ The EEOC argued that Honeywell's incentive-based biomedical testing was in violation of both the ADA and the Genetic Information Nondiscrimination Act ("GINA") and sought a preliminary injunction.¹⁰² Judge Montgomery denied the EEOC's re-

⁹³ Katie Thomas, *Companies Get Strict on Health of Workers*, N.Y. TIMES (Mar. 25, 2013), <http://www.nytimes.com/2013/03/26/business/companies-offer-workers-more-incentives-for-health-changes.html> [perma.cc/PJP4-9NKC].

⁹⁴ *Seff v. Broward Cnty., Fla.*, 691 F.3d 1221, 1224 (11th Cir. 2012).

⁹⁵ *Id.* at 1222.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.* at 1223, 1224.

¹⁰⁰ *Id.* at 1224. The safe harbor provision of the ADA that the court cites states that the ADA "shall not be construed to prohibit . . . 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 . . ." 42 U.S.C. § 12201(c)(2) (2014); *Seff*, 691 F.3d at 1224. The court interprets this to mean that the safe harbor provision "exempts certain insurance plans from the ADA's general prohibitions, including the prohibition of 'required' medical examinations and disability-related inquiries." *Seff*, 691 F.3d at 1223.

¹⁰¹ *EEOC v. Honeywell Int'l Inc.*, 2014 WL 5795481, at *6 (D. Minn. 2014).

¹⁰² *Id.* at *2.

quest to enjoin Honeywell from implementing the program, reasoning that the EEOC failed to establish a threat of irreparable harm.¹⁰³

II. THE DUPLICITOUS RAMIFICATIONS OF EMPLOYER WELLNESS PROGRAMS

The popularity of employer wellness programs does not appear to be lessening.¹⁰⁴ Employers are becoming more involved in health plans that encourage healthy behaviors to lower healthcare costs; it is apparent that a significant relationship exists between the degree of healthcare services received and the income, overall health, and in some cases, race, of employees.¹⁰⁵ Because of the potential detrimental effect wellness programs have on individuals with disabilities, low-income employees, and racial minorities, it is crucial to scrutinize the balance between the benefits and consequences of such programs.¹⁰⁶

A. Disputed Benefits of Employer Wellness Programs

As of 2013, approximately one half of American employers offered some type of wellness program or initiative.¹⁰⁷ The enthusiasm for these programs stems from evidence suggesting that employers trust wellness programs to improve employee health, cut down costs, and increase productivity.¹⁰⁸ For instance, a 2014 Kaiser Family Foundation survey found that twenty-eight percent of companies providing health benefits considered wellness programs to be “very effective” at controlling healthcare costs, and forty-three percent of companies considered wellness programs to be “somewhat effective.”¹⁰⁹ According to the survey, employers favor this strategy the most for containing healthcare costs, even over consumer-driven health plans and narrower provider networks.¹¹⁰

An unhealthy workplace contributes to increased health-related expenses in the forms of medical payments and costs associated with absenteeism.¹¹¹ Considering that the Center for Disease Control (CDC) predicts that chronic diseases will cost the nation’s healthcare system an estimated \$4.2 trillion an-

¹⁰³ See *id.* at *5. (“In sum, great uncertainty persists in regard to how the ACA, ADA and other federal statutes such as GINA are intended to interact Recent 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 . . .”).

¹⁰⁴ See Aizenman, *supra* note 80.

¹⁰⁵ See *id.*; Roberts, *supra* note 30, at 628–29.

¹⁰⁶ See Mello & Rosenthal, *supra* note 23, at 197.

¹⁰⁷ See MATTKE ET AL., *supra* note 51, at xiv.

¹⁰⁸ See KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, *supra* note 75, at 257; Susan Okie, *The Employer as Health Coach*, 357;15 NEW ENG. J. MED. 1465, 1466 (2007).

¹⁰⁹ See KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, *supra* note 75, at 261.

¹¹⁰ See *id.* at 262.

¹¹¹ Laura Anderko et al., *supra* note 26.

nually by 2023, a high return on investment is critical for employers implementing workplace wellness programs.¹¹² Moreover, there is also evidence suggesting that wellness programs are cost-effective, saving employers money in healthcare expenditures.¹¹³ In one study it was estimated that, on average, medical costs decrease about \$3.27 for every one dollar spent on employer wellness programs, and costs associated with absenteeism decrease about \$2.73 for every dollar spent.¹¹⁴ Companies such as Bank of America Corporation, Johnson & Johnson, and Chevron have reported savings from their wellness programs.¹¹⁵

Despite employers reporting positive outcomes, the overall effectiveness of these programs in lowering healthcare costs and improving health is generally uncertain.¹¹⁶ One study found that the use of rewards correlated with a decrease in tobacco use and overall body-mass index in participating employees, but did not impact their cholesterol levels.¹¹⁷ The study further explained that, for every ten dollars offered in incentives, average body-mass indices only decreased by about 0.03 pounds.¹¹⁸ In the same study, some employers vocalized that their wellness programs made positive impacts.¹¹⁹ Of employers surveyed, sixty percent reported that their programs did lower healthcare costs, but when examined critically, less than half of the employers surveyed regularly evaluated their programs and only two percent provided actual estimates of savings.¹²⁰ Another study conducted by a hospital system in St. Louis, Missouri stated that its workplace wellness program decreased hospitalizations among its employees, but did not save the hospital any money.¹²¹

Moreover, many studies on the effectiveness of these programs run up against inherent flaws.¹²² Selection bias, for example, is a concern.¹²³ In a study examining the overall health of individuals within a wellness program, if only the healthiest employees enrolled in the program, a comparison between participants and nonparticipants will likely be skewed to show more progress

¹¹² See *id.*

¹¹³ See *id.*

¹¹⁴ Katherine Baicker et al., *Workplace Wellness Programs Can Generate Savings*, 29:2 HEALTH AFF. 1, 5 (2010).

¹¹⁵ Anderko et al., *supra* note 26.

¹¹⁶ Kevin G. Volpp et al., *Redesigning Employee Health Incentives—Lessons from Behavioral Economics*, 365:5 NEW ENG. J. MED. 388, 390 (2011) (focusing on the potential health benefits of workplace wellness programs and arguing that more research needs to be done in this field to determine how wellness programs using incentives can produce health-related and cost-effective results).

¹¹⁷ MATTKE ET AL., *supra* note 51, at 87.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 53.

¹²⁰ *Id.*

¹²¹ Begley, *supra* note 50.

¹²² See Baicker et al., *supra* note 114, at 2.

¹²³ See *id.*

than is actually occurring.¹²⁴ Other concerns with conducting studies include low response rates and publication biases.¹²⁵

These issues are closely related to other concerns that potentially undermine the effectiveness of wellness programs and place sicker, low-income individuals and racial minorities at an immediate disadvantage.¹²⁶ Wellness programs rewarding employees for healthy behavior applaud those who may have already been practicing healthy habits.¹²⁷ In turn, when penalizing employees for unhealthy behavior, these programs are likely neglecting the individuals who need low healthcare costs the most.¹²⁸ Additionally, it is generally more difficult to engage individuals with unhealthy habits—for instance, sicker or low-income employees—in wellness programs.¹²⁹ Penalizing these individuals for their unhealthy behaviors will, therefore, not likely produce healthier outcomes.¹³⁰ Furthermore, there is reason to believe that employees who are incapable of changing their habits and cannot afford the punitive healthcare costs may get rid of their coverage altogether.¹³¹

Unfortunately, healthy food options for individuals in low socioeconomic circumstances are scarce, putting these populations at an inherent disadvantage in the battle for better health and wellbeing.¹³² The inaccessibility of nutritious

¹²⁴ See *id.*

¹²⁵ See *id.* (defining publication bias as the phenomenon in which “studies finding high returns may be more likely to be published”). A 2010 *Harvard Business Review* article examined the results of a study that followed a random sample of 185 workers without heart problems for six months. Leonard L. Berry et al., *What’s the Hard Return on Employee Wellness Programs?*, 88 HARV. BUS. REV. 104, 104 (2010). After receiving expert exercise training, fifty-seven percent of the subjects who were classified as “high risk” when the study commenced—according to blood pressure, body fat, and other factors—were converted to “low-risk” by the end of the study. *Id.* Jennifer S. Bard, however, points out in a *Journal of Law, Medicine & Ethics* article why the results of this study are misleading:

First, those in the study were well enough to participate in a vigorous exercising program. Second, lowering risk factors for heart disease is not the same as lowering incidence of heart disease. Finally, there is no way of knowing how long the lowered risk factors continued beyond the six month follow-up period or, of course, whether or not the subjects eventually contracted heart disease. This is because the subjects were not at high risk and would not be expected to actually experience for heart disease for many years.

Jennifer S. 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, 474–75 (2011).

¹²⁶ See Glatter, *supra* note 25; Thomas, *supra* note 93.

¹²⁷ See Thomas, *supra* note 93.

¹²⁸ *Id.*

¹²⁹ See Glatter, *supra* note 25.

¹³⁰ See *id.*

¹³¹ See *id.*

¹³² FOOD RESEARCH AND ACTION CTR., A HALF-EMPTY PLATE: FRUIT AND VEGETABLE AFFORDABILITY AND ACCESS CHALLENGES IN AMERICA 6 (Dec. 2011), http://frac.org/pdf/half_empty_plate_dec2011.pdf [perma.cc/Y33T-8RTN].

food, combined with the ease and availability of unhealthy food, is linked to obesity and diet-related diseases such as diabetes.¹³³ For instance, many low-income communities lack access to grocery stores that provide fresh produce and whole grains.¹³⁴ Of those in low-income neighborhoods, where individuals often rely on public transportation or walking, 23.5 million people live more than one mile away from a grocery store.¹³⁵ Further, when healthy food is available in low-income neighborhoods, it is typically more expensive than unhealthy food and is often low quality.¹³⁶ Moreover, individuals with limited resources tend to buy cheaper, energy-dense foods to stretch their budgets.¹³⁷ Albeit less expensive, these foods tend to be less nutritious and can exacerbate health issues and conditions such as obesity and diabetes.¹³⁸

B. Employer Wellness Programs Push Their Legal Limits

When it comes to instituting employer wellness programs, there is a lingering danger in the fact that their legal intricacies are not yet well understood.¹³⁹ Many programs require all employees to meet the same or similar health benchmarks.¹⁴⁰ These uniform approaches are not individualized to account for each employee's lifestyle and healthcare needs.¹⁴¹ Penalties for failing to satisfy one-size-fits-all benchmarks may disparately impact low-income individuals, individuals with disabilities, and some racial minorities who lack access to healthcare services and are inherently more vulnerable to health disparities.¹⁴² This injustice provides employers with a possible loophole to manipulate the system and reduce their expenses by shifting healthcare costs onto employees who cannot reach established benchmarks.¹⁴³ This cost shifting is

¹³³ U.S. DEP'T OF AGRICULTURE, ACCESS TO AFFORDABLE AND NUTRITIOUS FOOD: MEASURING AND UNDERSTANDING FOOD DESERTS AND THEIR CONSEQUENCES, at iii (2009), http://www.ers.usda.gov/media/242675/ap036_1_.pdf [perma.cc/Z5JD-UQVX] [hereinafter USDA ACCESS TO AFFORDABLE AND NUTRITIOUS FOOD].

¹³⁴ *Id.*

¹³⁵ *Id.* (defining a low-income neighborhood as an "area[] where more than 40 percent of the population has income at or below 200 percent of the Federal poverty thresholds").

¹³⁶ FOOD RESEARCH AND ACTION CTR., *supra* note 132, at 6.

¹³⁷ See USDA ACCESS TO AFFORDABLE AND NUTRITIOUS FOOD, *supra* note 133, at 55.

¹³⁸ See *id.*

¹³⁹ See Mello & Rosenthal, *supra* note 23, at 192.

¹⁴⁰ Written Testimony of Judith Lichtman, *supra* note 34.

¹⁴¹ *Id.*

¹⁴² See Roberts, *supra* note 30, at 618. Health disparities by income, education, race, ethnicity, and disability status are prominent in the United States. CTR. FOR DISEASE CONTROL & PREVENTION, HEALTH DISPARITIES AND INEQUALITIES REPORT—UNITED STATES, 2011 EXECUTIVE SUMMARY 2, <http://www.cdc.gov/minorityhealth/CHDIR/2011/ExecutiveSummary.pdf> [perma.cc/29QP-JEUP] [hereinafter CDC HEALTH DISPARITIES AND INEQUALITIES REPORT 2011]. Individuals in low socioeconomic brackets have a greater risk for morbidity and mortality, and are more likely to experience reduced access to healthcare and a lower quality of healthcare. *Id.*

¹⁴³ See Written Testimony of Judith Lichtman, *supra* note 34.

discriminatory and violates federal law when it adversely impacts the individuals who need affordable, accessible healthcare the most.¹⁴⁴

1. Americans with Disabilities Act: Forcing Voluntariness

The Americans with Disabilities Act (ADA) establishes that an employer cannot discriminate on the basis of a disability, make disability-related inquiries, or require medical examinations.¹⁴⁵ These prohibitions pose the most significant legal challenges to incentive-based employer wellness programs.¹⁴⁶ Broadly speaking, the ADA prohibits medical examinations or disability-related inquiries unless they are made after an offer for employment and are “job related and consistent with business necessity.”¹⁴⁷ If an employer implements a voluntary medical examination, it must be “part of an employee health program available to employees at that work site.”¹⁴⁸

Simply put, employer wellness programs, including health risk assessments and biometric testing, violate the ADA unless they are voluntary.¹⁴⁹ But this issue of voluntariness is riddled with legal ambiguities.¹⁵⁰ As mentioned in the Introduction, this was the heart of the Equal Employment Opportunity Commission (EEOC)’s case against Honeywell International Inc.¹⁵¹ Because there is a lack of coordination between agencies, legislative bodies, and courts concerning how to define voluntariness, it remains unclear whether or not the acceptance of an incentive in exchange for adopting healthy habits constitutes voluntariness.¹⁵² Moreover, it is questionable whether participation in a wellness program because of the possibility of incurring a penalty for non-

¹⁴⁴ See *id.*

¹⁴⁵ See 42 U.S.C. § 12112(d)(1) (2012).

¹⁴⁶ See *id.*; Robert R. Niccolini et al., Employee Wellness Programs: Unraveling the Knot of HIPAA, GINA, ADA, and Other Applicable Laws 8 (June 24, 2012) (written materials for American Health Lawyers Association In-House Counsel Program), https://www.healthlawyers.org/Events/Programs/Materials/Documents/IHC12/papers/A_niccolini_williams.pdf [perma.cc/78MH-VWZJ].

¹⁴⁷ 42 U.S.C. § 12112(d)(4)(a); *Watson v. City of Miami Beach*, 177 F.3d 932, 935 (11th Cir. 1999).

¹⁴⁸ 42 U.S.C. § 12112.

¹⁴⁹ Written Testimony of Judith Lichtman, *supra* note 34.

¹⁵⁰ See Niccolini et al., *supra* note 146, at 9. According to the EEOC, the term “voluntary” should be defined as “acting on one’s own free will *without* valuable consideration.” Steven C. Sizemore, *A Fatter Butt Equals A Skinnier Wallet: Why Workplace Wellness Programs Discriminate Against the Obese and Violate Federal Employment Law*, 11 WYO. L. REV. 639, 664 (2011) (emphasis added). The problem with this definition is that a reduction in insurance premiums or a financial reward can be considered consideration in exchange for participation in the employer’s wellness program. *Id.* Thus, workplace wellness programs are, in effect, providing valuable consideration. *Id.* If this is the case, they fall outside the EEOC’s definition of voluntary and therefore violate such acts as the ADA. *Id.* at 664–65.

¹⁵¹ *EEOC v. Honeywell Int’l Inc.*, 2014 WL 5795481, at *2 (D. Minn. 2014).

¹⁵² See Boselovic, *supra* note 14; see Sizemore, *supra* note 150, at 667.

participation may be considered voluntary.¹⁵³ These varying levels of inducement blur the legal lines when considering whether a wellness program is truly voluntary.¹⁵⁴

First, the concept of voluntariness is extremely concerning for low-income individuals.¹⁵⁵ Low-wage workers who cannot afford to sustain penalties may feel as though participation in a wellness program is their only option for avoiding negative incentives.¹⁵⁶ But this creates an unfortunate and unavoidable paradox.¹⁵⁷ Low-income and part-time employees—who may be working more than one job—generally cannot fully participate in their employer's wellness program due to the inflexibility in their schedules, lack of access to healthy resources, and a minimal understanding of the program's benefits.¹⁵⁸ In 2013, McDonald's released a sample monthly budget for its workers with the intention of providing financial guidance for those earning the minimum wage.¹⁵⁹ The budget assumed that an employee works two jobs and pays twenty dollars per month in healthcare costs.¹⁶⁰ Additionally, the budget did not include costs for childcare, groceries, or car-related expenses.¹⁶¹ The daily spending goal calculated to only twenty-five dollars per day per employee.¹⁶² This template budget not only highlights the near impossibility of making a living off the minimum wage, especially for those with families, it illustrates the severe inequities of employer wellness programs.¹⁶³ A low-wage employee, working two jobs with only twenty-five dollars of daily spending money, may feel that participation in a wellness program is mandatory to avoid the additional penalties and surcharges associated with non-participation.¹⁶⁴ This is a significant concern when considering the legal parameters of the

¹⁵³ See Written Testimony of Judith Lichtman, *supra* note 34.

¹⁵⁴ *Id.*

¹⁵⁵ See John DiNardo & Jill Horwitz, *Workplace Wellness Programs: Continuing the Discussion with Ron Goetzel*, HEALTH AFFAIRS BLOG (Oct. 30, 2013), <http://healthaffairs.org/blog/2013/10/30/workplace-wellness-programs-continuing-the-discussion-with-ron-goetzel/> [perma.cc/KEZ3-V9JQ].

¹⁵⁶ See Daniel Charles Rubenstein, *The Emergence of Mandatory Wellness Programs in the United States: Welcoming, or Worrisome?*, 12 J. HEALTH CARE L. & POL'Y 99, 102 (2009).

¹⁵⁷ See DiNardo & Horwitz, *supra* note 155.

¹⁵⁸ MATTKE ET AL., *supra* note 51, at 108.

¹⁵⁹ Lauren Shin, *Why McDonald's Employee Budget Has Everyone Up in Arms*, FORBES (July 18, 2013, 12:01 PM), <http://www.forbes.com/sites/laurashin/2013/07/18/why-mcdonalds-employee-budget-has-everyone-up-in-arms/> [perma.cc/NY2J-DPDT].

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*; see Mello & Rosenthal, *supra* note 23, at 195. The larger or more significant the financial incentive, the more likely it is that a court will consider participation in the program as non-voluntary. See Mello & Rosenthal, *supra* note 23, at 195.

ADA.¹⁶⁵ Moreover, most low-wage workers cannot meet their employer-designed goals because they cannot afford to adopt healthy habits, such as paying for gym membership and healthier foods.¹⁶⁶ This produces a dangerous Catch-22 and the very real potential that employer wellness programs will violate the ADA.¹⁶⁷

As previously mentioned, the Eleventh Circuit in *Seff v. Broward County* ruled on the issue, finding that a twenty-dollar penalty for noncompliance did not make the program involuntary.¹⁶⁸ Yet this decision is one of very few that addresses this issue.¹⁶⁹ The EEOC has not provided concrete recommendations on how “voluntary” should be interpreted under the ADA either.¹⁷⁰ The lack of a formal position on the matter only perpetuates these legal issues to the disadvantage of low-wage workers whose livelihoods depend on the rewards or penalties they incur through participation in their employer wellness programs.¹⁷¹

Wellness programs may also have a disparate impact on individuals with disabilities or chronic illnesses.¹⁷² Financial penalties for failing to meet health-related benchmarks may violate the ADA if an individual cannot reach these benchmarks due to a disability or illness.¹⁷³ For instance, a wellness program that promotes walking may create legal implications under the ADA if an employee is immobile due to a disability or illness.¹⁷⁴

2. Title VII of the Civil Rights Act of 1964

When a wellness program disproportionately impacts an individual or group of individuals on the basis of their race, sex, religion, or national origin it is in violation of Title VII of the Civil Rights Act of 1964 (Title VII).¹⁷⁵ These violations typically occur in two ways.¹⁷⁶ The first may occur when an

¹⁶⁵ See Mello & Rosenthal, *supra* note 23, at 195.

¹⁶⁶ See Roberts, *supra* note 30, at 629.

¹⁶⁷ See Mello & Rosenthal, *supra* note 23, at 195.

¹⁶⁸ *Seff*, 691 F.3d at 1224.

¹⁶⁹ Niccolini et al., *supra* note 146, at 9.

¹⁷⁰ *Id.*

¹⁷¹ See *id.*

¹⁷² See Roberts, *supra* note 30, at 616.

¹⁷³ Written Testimony of Judith Lichtman, *supra* note 34.

¹⁷⁴ *Id.* Employers may be able to avoid this liability if programs provide a reasonable alternative for meeting the health criteria, as required under the ACA. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158, 33,159 (June 3, 2013). But the restrictions surrounding what does and does not constitute a “reasonable alternative” create dangerous implications when low-wage workers and individuals with disabilities are disproportionately impacted by the inducement to participate in wellness programs. Heather Baird, *Healthy Compromise: Reconciling Wellness Program Financial Incentives with Health Reform*, 97 MINN. L. REV. 1474, 1483 (2013).

¹⁷⁵ See 42 U.S.C. § 2000e-2(a)(1) (2012).

¹⁷⁶ See Written Testimony of Judith Lichtman, *supra* note 34.

employer treats members of a protected class differently than others, which constitutes a disparate treatment claim.¹⁷⁷ To prove a disparate treatment claim an employee must show that the employer treated him or her less favorably because of his or her membership in a protected group.¹⁷⁸ Generally, a disparate treatment claim hinges on whether the employer had a discriminatory motive, although in most situations this motive can be inferred.¹⁷⁹ A Title VII violation can also occur when an employer implements an employment practice or program that adversely affects employees in a protected group.¹⁸⁰ Unlike a disparate treatment claim, this type of violation is considered disparate impact discrimination and can arise even when an employer's program is neutral on its face.¹⁸¹ The employee merely needs to prove that a specific policy has adversely impacted an individual or group of individuals on the basis of race, sex, color, or national origin.¹⁸² Penalties, surcharges, and the denial of rewards for noncompliance or for failing to meet health-related benchmarks can dangerously toe the line of Title VII violations.¹⁸³ But this punitive aspect of employer wellness programs is not the only concern when considering Title VII.¹⁸⁴ Even if a wellness program offers a reward to employees who meet certain health criteria, the program can still disparately impact those individuals who do not achieve the reward.¹⁸⁵ Regardless of whether an employer labels its incentives as "penalties" or "rewards," the program will still offend Title VII if health insurance costs are disproportionately shifted onto a protected group.¹⁸⁶

Race and ethnicity are inherently linked to health disparities in the United States.¹⁸⁷ Racial minorities are more vulnerable to diabetes, heart disease, and obesity.¹⁸⁸ Diabetes is more prevalent among African Americans than white

¹⁷⁷ See *id.* Title VII defines "protected class" as an individual's "race, color, religion, sex, or national origin." 42 U.S.C. § 2000e-2(a)(1).

¹⁷⁸ See, e.g., *Dep't of Water & Power v. Manhart*, 435 U.S. 702, 711 (1978) (determining that the City of Los Angeles' Department of Water and Power violated Title VII by requiring female employees to make larger contributions to the city's pension fund than male employees).

¹⁷⁹ Written Testimony of Judith Lichtman, *supra* note 34; see *Manhart*, 435 U.S. at 711 n.20.

¹⁸⁰ See *Griggs v. Duke Power Co.*, 401 U.S. 424, 431 (1971) (holding that plaintiffs may bring disparate impact claims under Title VII).

¹⁸¹ *Id.* Title VII "proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation." *Id.*

¹⁸² *Id.* at 432 ("Good intent or absence of discriminatory intent does not redeem employment procedures . . .").

¹⁸³ Written Testimony of Judith Lichtman, *supra* note 34.

¹⁸⁴ See *id.*

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ See CTR. FOR DISEASE CONTROL & PREVENTION, FACT SHEET—CDC HEALTH DISPARITIES AND INEQUALITIES REPORT U.S., 2011, at 1, <http://www.cdc.gov/minorityhealth/CHDIR/2011/FactSheet.pdf> [perma.cc/Q3K6-DXU3].

¹⁸⁸ Written Testimony of Judith Lichtman, *supra* note 34.

Americans.¹⁸⁹ Approximately 6.5% of white males and 5.4% of white females have diagnosed diabetes in the United States, while 9.9% of African American males and 9% of African American females are diagnosed with the disease.¹⁹⁰ Compared to non-Hispanic white Americans, African Americans are two times as likely to be diagnosed with diabetes.¹⁹¹ Among Asian populations, the prevalence of diabetes is approximately 7.8% among males and 5.5% among females.¹⁹² Hispanic adults are more likely than non-Hispanic white Americans to have diabetes and are even more likely to be diagnosed with certain types of cancer.¹⁹³

Moreover, heart disease is the first leading cause of death in the United States; its prevention is strongly linked to modifiable risk factors such as high cholesterol, blood pressure, diabetes, obesity, tobacco use, and lack of exercise.¹⁹⁴ American Indians and multiracial Americans are more likely than non-Hispanic white Americans to have a history of myocardial infarctions and coronary heart disease.¹⁹⁵ And more African American women have died before their seventy-fifth birthday as a result of coronary heart disease than white American women.¹⁹⁶ A higher percentage of African American women have also suffered strokes as compared to white American women.¹⁹⁷ In terms of obesity, the prevalence is notably higher in African Americans than white Americans.¹⁹⁸

Employer wellness programs may be designed with the intention to correct some of these aforementioned health issues, but they still have the potential to cross the legal boundaries of Title VII when they shift costs onto populations that cannot meet designated health criteria.¹⁹⁹ Because certain racial mi-

¹⁸⁹ *Age-Adjusted Rate per 100 of Civilian Noninstitutionalized Population with Diagnosed Diabetes, by Race and Sex, United States, 1980–2011*, CTR. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/diabetes/statistics/prev/national/figraceethsex.htm> [perma.cc/L8G7-GSKJ] (last updated Dec. 1, 2015) [hereinafter CDC Rate of Population with Diagnosed Diabetes].

¹⁹⁰ *Id.* These percentages are adjusted to account for age factors. Zhiwei Zeng, *Adding the Feature of Age Adjustment for Survey-related Procedures in SAS—Age Adjusting Prevalence Estimates from Population Based Surveys* (2007), http://www.lexjansen.com/wuss/2007/CodersCorner/COD_Zheng_AddingTheFeature.pdf [perma.cc/ENP2-7M6Q]. For instance, diabetes is more prevalent in older populations. *Id.* Therefore, age-adjustment strategies are used so the rate of a disease in a specific region can be compared against people of similar ages. *Id.*

¹⁹¹ Written Testimony of Judith Lichtman, *supra* note 34.

¹⁹² CDC Rate of Population with Diagnosed Diabetes, *supra* note 189.

¹⁹³ Written Testimony of Judith Lichtman, *supra* note 34.

¹⁹⁴ *Morbidity and Mortality Weekly Report: Prevalence of Heart Disease - United States, 2005*, CTR. FOR DISEASE CONTROL AND PREVENTION (Feb. 16, 2007), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5606a2.htm> [perma.cc/5Q8P-8EGS].

¹⁹⁵ *Id.*

¹⁹⁶ CDC HEALTH DISPARITIES AND INEQUALITIES REPORT 2011, *supra* note 142.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ Written Testimony of Judith Lichtman, *supra* note 34.

norities are more susceptible to health problems such as diabetes, heart disease, and obesity, punitive measures for failing to reach benchmarks, such as lower body mass index or lower cholesterol, have the very real potential to disparately impact these populations.²⁰⁰ To surpass this Title VII hurdle, an employer would have to show that the program is “consistent with business necessity,” “necessary to the safe and efficient operation of the business,” and “of great importance to job performance.”²⁰¹ However, if an alternative practice or procedure exists that can effectively carry out the purpose of the program and is less discriminatory, then the program in question would not be considered a business necessity.²⁰²

III. PROPOSED SOLUTIONS TO COMBAT DISCRIMINATION IN WORKPLACE WELLNESS PROGRAMS

Curbing rising healthcare costs and increasing access to quality healthcare are two critical issues facing the nation that are fundamentally at odds with each other.²⁰³ As a solution to escalating healthcare costs, many employers are turning to workplace wellness programs.²⁰⁴ Despite their disputed benefits, because of their disparate impact on certain employees, workplace wellness programs may serve as a subterfuge for unlawful discrimination.²⁰⁵

Abandonment of workplace wellness programs seems unlikely due to endorsements from the Affordable Care Act (ACA) and soaring healthcare costs.²⁰⁶ Thus, in order to properly protect those who are most vulnerable to disparate treatment from these programs—low-income individuals, individuals with disabilities, and racial minorities—resulting from discriminatory cost-shifting, the following changes should be made: (1) the Equal Employment Opportunity Commission (EEOC) must provide guidance regarding workplace wellness discrimination; (2) the EEOC needs to adequately exercise its power as an enforcer of anti-discrimination laws within workplace wellness employ-

²⁰⁰ *See id.*

²⁰¹ 42 U.S.C. § 2000e-2(k)(1)(A)(i) (2012); *see also Ricci v. DeStefano*, 557 U.S. 557, 589, 622–23 n.3 (2009) (holding that the City of New Haven, Connecticut’s firefighter test violated Title VII because the city lacked a strong basis in evidence that it would have been subject to disparate impact liability if it had failed to take the discriminatory action); *Williams v. Colo. Springs, Colo. Sch. Dist. No. 11*, 641 F.2d 835, 842 (10th Cir. 1981) (determining that a disparate impact is found when employment practices are facially neutral but in fact adversely impact one group over another and cannot be justified by a business necessity).

²⁰² *See Ricci*, 557 U.S. at 592, 593.

²⁰³ *See Rubenstein, supra* note 156, at 99–100. The U.S. is expected to spend nearly \$4.3 trillion on health-related services by 2018. *Id.* This figure is more than twice the amount the U.S. was spending in 2008. *Id.* Despite this expense, in terms of quality and access to healthcare, the U.S. remains one of the lowest-ranking developed countries. *Id.*

²⁰⁴ *Id.* at 100.

²⁰⁵ *See Written Testimony of Judith Lichtman, supra* note 34.

²⁰⁶ *See Glatter, supra* note 25.

ment; and (3) the Health Insurance Portability and Accountability Act (HIPAA) must be amended to better define “voluntariness” within the realm of incentives and penalties.²⁰⁷

A. The EEOC’s Obligation to Issue Clear and Explicit Guidance

The U.S. Congress and the U.S. Supreme Court have yet to concretely address and clarify the factors that constitute discriminatory practice in workplace wellness programs.²⁰⁸ This lack of clarity has left federal and state courts directionless, and facilitates inconsistent and unpredictable rulings that will mislead and confuse employers and employees.²⁰⁹

To help mitigate this problem, the EEOC must offer clear and explicit guidance regarding discriminatory practices in workplace wellness programs.²¹⁰ As a federal government agency and the leading investigative authority on charges of discrimination against employers, the EEOC is a persuasive authority within the court system.²¹¹ The agency is therefore in the prime position to provide clarity to these issues by explaining the types of practices that violate anti-discrimination laws and promulgating lawful frameworks for wellness programs.²¹²

In 2000, the EEOC issued a compliance manual addressing discrimination in regards to employee benefits.²¹³ The purpose of the manual was to provide

²⁰⁷ See Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,159 (June 3, 2013); Written Testimony of Judith Lichtman, *supra* note 34.

²⁰⁸ See Sizemore, *supra* note 150, at 667.

²⁰⁹ See *id.* For instance, some states broadly define the term “disabled” under the ADA and consequently cover more individuals who may qualify for this protection. See Lucinda Jesson, *Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations*, 15 VA. J. SOC. POL’Y & L. 217, 265 (2008). Minnesota’s definition of “disability” is interpreted more broadly than that of the ADA. See *id.* Minnesota defines a “disability” as “a physical, sensory, or mental impairment which *materially* limits one or more major life activities.” MINN. STAT. ANN. § 363A.03 (2007) (emphasis added). On the other hand, the ADA defines a “disability” as a physical or mental impairment that *substantially* limits one or more major life activities of such individual. 42 U.S.C. § 12102 (emphasis added). As another example, some state courts are grappling with the issue of whether obesity qualifies as a disability within the scope of employment discrimination and are producing conflicting rulings. Compare *Viscik v. Fowler Equip. Co.*, 800 A.2d 826, 836 (N.J. 2002) (determining that the former employee’s obesity constituted a handicap under the state’s discrimination law), with *Cassista v. Cmty. Foods, Inc.*, 856 P.2d 1143, 1154 (Cal. 1993) (finding insufficient evidence that plaintiff’s weight of more than 300 pounds was the result of a physiological condition or disorder, and thus the plaintiff failed to establish a prima facie case of employment discrimination).

²¹⁰ Written Testimony of Judith Lichtman, *supra* note 34.

²¹¹ Sizemore, *supra* note 150, at 664 (“While the EEOC’s informal guidance is not binding, it is persuasive and carries the weight of the administrative agency charged with interpreting and enforcing the ADA and GINA.”).

²¹² See Written Testimony of Judith Lichtman, *supra* note 34.

²¹³ See *id.*; *EEOC Employment Compliance Manual, Chapter 3: Employment Benefits*, EQUAL EMPLOYMENT OPPORTUNITY COMM’N (Oct. 3, 2000), <http://www.eeoc.gov/policy/docs/benefits.html> [perma.cc/QPA3-FGM9] [hereinafter *EEOC 2000 Employment Benefits Compliance Manual*].

guidance on discriminatory issues relating to life and health insurance benefits, disability benefits, severance benefits, pension benefits, and early retirement incentives.²¹⁴ The manual also touched upon disparate impact claims in employee benefits as they relate to Title VII of the Civil Rights Act of 1964 (Title VII) and Americans with Disabilities Act (ADA) violations.²¹⁵ However, the manual, now outdated by more than a decade, did not provide specific guidance regarding discrimination within workplace wellness programs.²¹⁶ Because employers depend on the EEOC for direction when developing workplace wellness programs, it is imperative for the EEOC to release guidance explaining how to best craft programs that do not violate federal anti-discrimination laws.²¹⁷ Employers need to understand the intricacies of the law in order to develop programs that do not disproportionately impact or raise costs for low-income individuals or other protected groups, such as racial minorities and individuals with disabilities.²¹⁸ For instance, the EEOC can develop and issue the framework for programs that are truly voluntary and do not penalize employees for failing to meet benchmarks, and the EEOC could help establish programs that provide reasonable alternatives for those individuals who cannot satisfy employer-based health factors.²¹⁹

B. The EEOC as a Critical Enforcer of the Law

In its five-decade history, the EEOC has processed the majority of employment discrimination claims that are not pursued in the private sector, yet discrimination in the workplace remains a prevalent problem.²²⁰ The legal reasons behind this may primarily be attributed to two factors: the EEOC's evolution from an investigative unit to an intake and processing machine and the EEOC's limited role in employment litigation.²²¹ Thus, to forcefully wield

²¹⁴ *EEOC 2000 Employment Benefits Compliance Manual*, *supra* note 213.

²¹⁵ *Id.*

²¹⁶ *See id.*

²¹⁷ Written Testimony of Judith Lichtman, *supra* note 34.

²¹⁸ *Id.*

²¹⁹ *Id.* The ACA requires a reasonable alternative standard to be offered to individuals for whom "it is unreasonably difficult *due to a medical condition* to satisfy the otherwise applicable standard (or for whom it is *medically inadvisable* to attempt to satisfy the otherwise applicable standard)." *See Incentives For Nondiscriminatory Wellness Programs in Group Health Plans*, 78 Fed. Reg. at 33,159 (June 3, 2013) (emphasis added). However, no definition of "medical condition" is provided. *See id.* Any plan under the ACA must disclose the availability of the alternative standard in the program materials. *Id.* Yet, from these regulations, it is not clear whether a condition such as obesity or high cholesterol would fall under the category of a medical condition. Mello & Rosenthal, *supra* note 23, at 194.

²²⁰ Michael Selmi, *The Value of the EEOC: Reexamining the Agency's Role in Employment Discrimination Law*, 57 OHIO ST. L.J. 1, 1 (1996); Nancy M. Modesitt, *Reinventing the EEOC*, 63 SMU L. REV. 1237, 1245 (2010).

²²¹ Modesitt, *supra* note 220, at 1241, 1245.

whatever resources the agency has, it needs to pursue claims that relate to significant legal issues and provide opportunities to force courts to expound the law.²²²

First, the EEOC has been unable to keep up with the sheer number of charges due to administrative burden.²²³ When the EEOC was initially created, it was primarily intended to investigate claims relating to employer discrimination.²²⁴ Congress, however, did not appropriately account for the number of claims the EEOC would have to process and, as a result, the agency collected an insurmountable backlog.²²⁵ As University of Baltimore Law School Professor Nancy M. Modesitt colorfully explained, “This backlog of charges has continued to keep the EEOC in the position where it is treading water—managing the huge number of claims without substantively investigating them.”²²⁶ Thus, the EEOC fell into a pattern in which it accepted charges it was unable to sufficiently investigate.²²⁷

Second, unlike other federal agencies, the EEOC lacks the power to sanction violators.²²⁸ Because of this, its enforcement power rests primarily in its ability to file suit against employers on behalf of employees.²²⁹ The resulting problem is that the EEOC tends to focus its efforts on smaller cases that typically involve lost wages of less than ten thousand dollars.²³⁰ This can be linked to several factors, including the EEOC’s ability to select its own cases, allowing the agency to select smaller cases with higher success rates, or it may be linked to the size of the EEOC’s litigation program.²³¹ Because of the EEOC’s

²²² See *id.* at 1263. To help craft the most effective cases, the EEOC should develop comprehensive screens for warning signs of discriminatory employer wellness programs. See Written Testimony of Judith Lichtman, *supra* note 34. For instance, the EEOC needs to be able to quickly flag programs that raise costs for or penalize low-income individuals, racial minorities, or individuals with disabilities. See *id.* Or, programs whose rewards effectively shut out employees who are unable to meet health-related benchmarks. See *id.*

²²³ Modesitt, *supra* note 220, at 1241.

²²⁴ *Id.* at 1240.

²²⁵ *Id.* at 1241.

²²⁶ *Id.*

²²⁷ *Id.* One study has found that, in 2008, the EEOC spent more than \$270 million on the enforcement of anti-discrimination laws in private sector employment. *Id.* at 1243–44. Yet of this \$270 million, nearly \$162 million was spent on processing administrative charges. *Id.* at 1244. This means that the EEOC spent more than sixty percent of its budget on intake responsibilities alone. *Id.* The study further reported that the EEOC’s budget has mostly followed the same pattern in recent years. *Id.*

²²⁸ *Id.* at 1245.

²²⁹ *Id.*

²³⁰ Selmi, *supra* note 220, at 25–26. An in-depth 1992 study found that, in settlement, the EEOC was able to recover on average \$18,174 per plaintiff. *Id.* at 19. The variance, however, was high and the study further expounded that seventy-five percent of the cases settled for less than \$20,000. *Id.*

²³¹ See Modesitt, *supra* note 220, at 1248. In 2008, for instance, the EEOC received only one-third of the budget allotted for the agency’s intake role. *Id.* at 1245. This amounted to a relatively small figure of only fifty-seven million dollars. See *id.* It is worth noting that there is a common mis-

limited enforcement power, it must systematically and continuously pursue significant litigation that protects vulnerable and low-wage workers against discriminatory cost-shifting practices that issue penalties for noncompliance.²³² There is no doubt that the EEOC has limited resources in its litigation program.²³³ But this can be no excuse for inaction.²³⁴ The EEOC needs to apply pressure on employers and courts; by continuously pursuing meritorious litigation, employers will gradually learn to comply with nondiscrimination laws as they design and implement their workplace wellness programs.²³⁵ This will also help relieve the administrative burden of collecting all complaints of discrimination.²³⁶ For instance, the agency would not have to manage the mass of complaints it receives each year, including drafting and mailing the thousands of right-to-sue letters that are required before an employee is able to bring suit in court.²³⁷ If the EEOC limits the number of cases it investigates and litigates, and focuses solely on significant, novel, meritorious claims, it can better fulfill the job that it has been set out to do—end discrimination in the workplace.²³⁸

C. The Need to Amend HIPAA

Many employers allege that their workplace wellness programs are voluntary.²³⁹ Yet the imposition of financial incentives and penalties to induce participation casts serious doubt on such assertions.²⁴⁰ For instance, a sizeable reward or reduction in premiums may not sway a high-earning individual to participate in a wellness program, but any reward or reduction may be very appealing to a low-income individual.²⁴¹ Low-income employees are more likely to take advantage of financial inducements and thus, more often than not, find themselves at the economic will of their employers.²⁴²

conception that cases for small damages do not make enough of an impact to deter employers from implementing discriminatory cost-shifting measures. *See Selmi, supra* note 220, at 33. But even low damage claims serve an incredibly important purpose in the anti-discrimination battle against employer wellness programs. *See id.* Without them, employers would be of the mindset that they are allowed to discriminate against employees so long as the potential damages remained below a certain point. *Id.*

²³² Written Testimony of Judith Lichtman, *supra* note 34. Significant claims are those involving novel legal issues that provide courts with opportunities to develop the law. Modesitt, *supra* note 220, at 1263.

²³³ *See* Modesitt, *supra* note 220, at 1246.

²³⁴ *See id.* at 1263.

²³⁵ *See Selmi, supra* note 220, at 33.

²³⁶ Modesitt, *supra* note 220, at 1263.

²³⁷ *Id.*

²³⁸ *See id.*

²³⁹ Sizemore, *supra* note 150, at 663.

²⁴⁰ *Id.*

²⁴¹ *Id.* at 664.

²⁴² *See id.*

As previously noted, there is a disconcerting lack of guidance and coordination between agencies, legislative bodies, and courts concerning this issue of voluntariness.²⁴³ This is especially troublesome when it comes to the protection of low-income individuals, racial minorities, and individuals with disabilities.²⁴⁴ One possible way to mitigate this is to address the root of the problem: HIPAA.²⁴⁵ HIPAA's nondiscrimination requirements apply to all health plans, whether public or private.²⁴⁶ But as it currently stands, HIPAA only monitors and limits penalties and incentives within group health plans.²⁴⁷ A wellness program that encourages an employee's personal responsibility in healthcare falls outside of HIPAA's purview.²⁴⁸

HIPAA needs to be amended to provide limitations on an employee's personal responsibility in his or her healthcare, and to guarantee that a participant's involvement in a workplace wellness program is a purely voluntary decision.²⁴⁹ Specifically, any modification to HIPAA must include a clear, precise, and fair definition of "voluntary" that can cohesively supplant the discriminatory practices inherent in employer wellness programs.²⁵⁰

These necessary amendments will consequentially impact all employers with applicable, lawful health plans under HIPAA.²⁵¹ With additional clarity as to the intricacies of "voluntariness," employers will be able to better design their wellness programs by providing a multitude of options for employees.²⁵² Wellness plans need to be diverse in options to account for each individual's socioeconomic and health-related circumstances, instead of a one-size-fits-all approach that requires participation in order to obtain a benefit.²⁵³ By assuring that a participant's involvement in a workplace wellness program is truly voluntary, compliance with the ADA and Title VII will likely be met and the dan-

²⁴³ Niccolini et al., *supra* note 146.

²⁴⁴ See Jesson, *supra* note 209, at 264–65.

²⁴⁵ See Incentives For Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158 (June 3, 2013).

²⁴⁶ Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. § 1181 (2012); Jesson, *supra* note 209, at 245.

²⁴⁷ See 45 C.F.R. § 146.121(b)(2)(i)(B) (2015).

²⁴⁸ See *id.*; Jesson, *supra* note 209, at 246 n.133. "[T]here is an exception to the general rule prohibiting discrimination based on a health factor if the reward, such as a premium discount or waiver of a cost-sharing requirement, is based on participation in a program of health promotion or disease prevention." See T.D. 9298, 2007-6 I.R.B. 438 (Feb. 5, 2007).

²⁴⁹ See Jesson, *supra* note 209, at 294.

²⁵⁰ See *id.* In his 2009 *Journal of Health Care & Law Policy* article, Daniel Charles Rubenstein recommends that, as a first step, employers should eliminate programs that penalize employees for noncompliance, and, at the bare minimum, implement programs that offer rewards to employees for meeting benchmarks. See Rubenstein, *supra* note 156, at 117–18.

²⁵¹ See Jesson, *supra* note 209, at 245, 295.

²⁵² See *id.* at 245.

²⁵³ See Written Testimony of Judith Lichtman, *supra* note 34.

ger of employee discrimination on the basis of income, race, and disability will subside.²⁵⁴

CONCLUSION

Workplace wellness programs are expanding at an exponential rate and are quickly becoming the norm for employers hoping to lower healthcare costs and improve the overall health and longevity of their workforce. These programs serve a significant role in incentivizing employees to get healthy, thereby reducing health-related illnesses and fostering the wellbeing of workers. Yet an increased risk of abuse flows as an inevitable result of this system: through the issuance of rewards and penalties, employers will disproportionately shift the cost of healthcare onto vulnerable populations who need affordable healthcare services the most. As a society, we should not tolerate the inherent discrimination that occurs within these programs as healthcare costs are shifted onto low-income individuals, certain racial minorities, and individuals with disabilities. To combat this problem, the Equal Employment Opportunity Commission must step up as an authority in this field to guide implementation and enforcement of lawful wellness programs. Additionally, the Health Insurance Portability and Accountability Act should be modified to ensure that all workplace wellness programs are genuinely and effectively voluntary. All working Americans—regardless of background, race, health status, or income—should have the choice to voluntarily enjoy the benefits of workplace wellness programs, without running the risk of incurring higher healthcare costs.

²⁵⁴ See Jesson, *supra* note 209, at 295.