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EMPLOYER WELLNESS INCENTIVES, THE ACA, AND THE ADA: RECONCILING POLICY OBJECTIVES

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Can employer-sponsored wellness programs promote health without discriminating against individuals on the basis of their health? The answer to this question surely must be yes. Employers that increase the availability of healthy food to their employees, provide health information, or support physical activity help build a foundation for healthy living. The fact that employers can promote health, however, does not mean that they do promote health, that they promote health equally for all employees, or that their interventions achieve success in improving health status. Much will necessarily depend on employer wellness program design, employee engagement, and the characteristics of the employee population.

As legal scholars have recognized, numerous state and federal laws and regulations shape the design of wellness programs, particularly programs that rely on financial incentives.¹ Much of the substantive exploration of legal limits for these programs has focused on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), its regulations, and the closely related provisions in the Patient Protection and Affordable Care Act of 2010 (ACA). This now relatively well-defined regulatory regime aims to facilitate the use of financial incentives to promote health, while precluding discrimination based on health status in group health plans. Attention has now turned to an overlapping but distinct worry about wellness

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

programs: the possibility that these programs might discriminate against individuals based on disability.²

This concern is not new. It has probably existed since the advent of wellness programs, and policymakers have long made clear the possibility that wellness incentives might run afoul of a variety of laws targeting discrimination. Against this backdrop, it is no surprise that employers have long sought to determine the relevance of these laws to their wellness programs. Legal scholars have started exploring the implications of statutes such as the Americans with Disabilities Act of 1990 (ADA), as amended, and the Genetic Information Nondiscrimination Act of 2008 (GINA).³

What is new, however, is that federal regulators are now taking steps that are likely to clarify how some of these antidiscrimination statutes apply to wellness programs. In 2014, the Equal Employment Opportunity Commission (EEOC) filed suit against a large employer, alleging that its wellness program violated both the ADA and GINA.⁴ In 2015, the EEOC issued a proposed rule under the ADA that has the potential to influence the design of future wellness programs and create a platform for broader discussion about employers' roles in health promotion, the desirability of the use of financial levers to influence behavior, and the risks that current practices may pose for individuals with disabilities.⁵

At the heart of the proposed rule is the following question: Under what circumstances is an employer permitted to make disability-related inquiries or conduct medical examinations? When the ADA was enacted, Congress sought to limit disability-related stigma and discrimination by prohibiting such inquiries and examinations unless they are job-related and consistent with business necessity.⁶ Recognizing that wellness programs might incorporate inquiries or examinations that would run afoul of this prohibition, Congress created an exception for "voluntary medical examinations,

2. See, e.g., E. Pierce Blue, *Wellness Programs, the ADA, and GINA: Framing the Conflict*, 31 HOFSTRA LAB. & EMP. L.J. 357 (2014).

3. See, e.g., *id.*; see also 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*, 309 J.L. MED. & ETHICS 469 (2011); Mark A. Rothstein & Heather L. Harrell, *Health Risk Reduction Programs in Employer-Sponsored Health Plans: Part II-Law and Ethics*, 51 J. OCCUPATIONAL & ENVIRONMENTAL MED. 951 (2009).

4. See *infra* Part III.C.

5. See *infra* Part III.C.

6. See discussion *infra* Part III.B.

including voluntary medical histories, which are part of an employee health program.”⁷ In its proposed rule, the EEOC describes the requirements that an employer-sponsored wellness program must meet before it can fall within this exception. The rule allows employers to offer rewards or impose penalties in connection with wellness programs that involve disability-related inquiries or examinations, but it limits their magnitude, an approach similar to the one adopted by the ACA.

Advocates for individuals with disabilities, large employers, insurers, wellness services providers, and others submitted hundreds of comments that reflected widely varying responses to the proposed rule.⁸ A number of commenters argued that the proposed ceiling permits incentives that are too burdensome, and some advocated for prohibiting incentives entirely. Others argued that the proposed ADA incentive rules should be patterned even more closely after the ACA regulations, which would have the effect of loosening the proposed incentive limits.

In this essay I argue that an examination of the policy objectives underlying the ACA, the ADA, and their exceptions points toward a middle path. The antidiscrimination provisions for health plans are designed to break the link between employees’ health status and their health insurance costs. HIPAA and ACA regulations provide an exception for wellness incentives, but limit the incentives’ potential threat to insurance affordability by imposing a ceiling on them. By contrast, the ADA provision at the center of the current debate is intended to reduce the risks of discrimination and stigma by blocking employers’ attempts to elicit disability-related information. The ADA’s wellness program exception allows employees to participate in programs that involve these risks—but only if they do so voluntarily. The primary purpose of an incentive limit in the ADA context, then, is not to ensure insurance affordability, but instead to ensure the voluntariness of employees’ provision of information. I argue that incentives can be compatible with voluntariness, and should therefore be permitted under the ADA. I also conclude, however, that the ADA’s focus on voluntariness should lead to incentive limits that are structured differently from those under the

7. 42 U.S.C. § 12112(d)(4)(B) (2013).

8. *See Amendments to Regulations Under American with Disabilities Act*, REGULATIONS.GOV (June 19, 2015, 11:59 PM), <http://www.regulations.gov/#!docketDetail;D=EEOC-2015-0006> (313 comments); *see also* discussion *infra* Part IV.

ACA.

Part I of this essay discusses the pre-ADA, pre-HIPAA origins of wellness programs, describes their current configurations, and presents evidence of their impact. Part II lays out the HIPAA–ACA regulatory framework that applies to wellness incentives and then explores its implications. Part III examines the relationship between disability and wellness, and then considers how the ADA might apply to wellness incentives, highlighting longstanding legal uncertainties surrounding this question. It details developments in the past year that are relevant to the debate, and concludes with a description of key incentive provisions in the EEOC’s April 2015 proposed rule. Part IV offers an analysis of the proposed rule’s incentive ceiling in light of the differing objectives of the ACA and the ADA. After exploring what the ADA’s requirement for voluntariness might mean in a general sense, it considers its implications for questions related to the incentive ceiling design, such as whether the ceiling should be adjusted when incentives are offered to family members, and whether the ceiling should apply to incentives offered outside of health plans. Part V concludes with a brief discussion of the broader concerns involving wellness programs, and a call for evidence-based regulation.

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I. AN INTRODUCTION TO EMPLOYER WELLNESS PROGRAMS

A. *Wellness Programs: Past and Present*

Given the legal uncertainty surrounding wellness programs, it might seem that they are relatively new additions to the corporate landscape. They are not. Writing in 1987, a leading health and wellness scholar stated that “[i]n the past decade work-site health promotion or ‘wellness’ emerged as a manifestation of the growing national interest in disease prevention and health promotion.”⁹ The growing national interest in health promotion coincided with rapidly rising health care costs; a desire to contain health care costs was the “dominant stated rationale” for corporate health promotion in this era.¹⁰ Other benefits attributed to wellness programs in the 1980s included increased productivity, decreased absenteeism, reduced disability and premature death, better morale, reduced employee turnover, and improved worker health in general.¹¹

Employer-sponsored wellness programs diffused rapidly in the 1980s. The first National Survey of Worksite Health Promotion Activities, a survey of private worksites with at least fifty employees conducted in the late 1980s, found that the majority of worksites had at least some health promotion activities, with the prevalence of activities increasing with employer size.¹² Nearly half of employers with 750 or more employees offered programs targeting blood pressure control, weight control, nutrition, or back problems.¹³ More than half had programs involving smoking cessation, exercise, or

9. Peter Conrad, *Wellness in the Work Place: Potentials and Pitfalls of Work-Site Health Promotion*, 65 THE MILBANK Q. 255, 255 (1987).

10. *Id.* at 257.

11. *Id.* at 257–58; Carlos Castillo-Salgado, *Assessing Recent Development and Opportunities in the Promotion of Health in the American Workplace*, 19 SOC. SCI. & MED. 349, 353 (1984); Roberta B. Hollander & Joseph J. Lengeremann, *Corporate Characteristics and Worksite Health Promotion Programs: Survey Findings from Fortune 500 Companies*, 26 SOC. SCI. & MED. 491, 492 (1988).

12. Jonathan E. Fielding & Philip V. Piserchia, *Frequency of Worksite Health Promotion Activities*, 79 AM. J. PUB. HEALTH 16, 18 (1989).

13. *Id.*

stress management.¹⁴ Smoking cessation programs, offered by more than a third of all surveyed employers, were the most common type of wellness activity.¹⁵ By the end of the 1980s, many well-known corporations had adopted wellness programs, including Honeywell, Safeway, Sara Lee, AT&T, Johnson & Johnson, Lockheed, IBM, and Kimberly-Clark.¹⁶

This early growth of workplace wellness programs was supported by federal policymakers. The federal government sponsored a national conference on health promotion programs in occupational settings in 1979.¹⁷ By 1989, the U.S. Office of Disease Prevention and Health Promotion was developing a clearinghouse to make information on health programs accessible to small companies.¹⁸

Today a similar role is played by the Centers for Disease Control and Prevention, which provides information and planning tools,¹⁹ and operates the National Healthy Worksite Program.²⁰ Some state governments have supported the development of wellness programs through tax credits and other programs.²¹ There are also now countless nonprofit organizations and for-profit consultants, employee benefits companies, and other organizations that have accelerated the spread of employer-sponsored wellness programs nationwide.²²

Wellness programs have become a common feature of the employment landscape, especially for larger employers. A 2014

14. *Id.*

15. *Id.* at 16.

16. Conrad, *supra* note 9, at 256 (listing corporations with worksite health promotion programs); Marjory Roberts & T. George Harris, *Wellness at Work*, PSYCHOL. TODAY, May 1989, at 54, 56–58 (profiling wellness programs).

17. Hollander & Lengermann, *supra* note 11, at 491.

18. Roberts & Harris, *supra* note 16, at 54–55.

19. *Workplace Health Promotion*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/workplacehealthpromotion/> (last visited June 27, 2015).

20. *National Healthy Worksite Program*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nationalhealthyworksite/about/index.html> (last visited June 27, 2015).

21. See, e.g., 105 MASS. CODE REGS. 216.000 (2015) (Massachusetts Wellness Tax Credit Incentive); Nat'l Conference of State Legislatures, *State Wellness Legislation, 2006-2010*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/state-wellness-legislation/default.aspx> (last updated July 2010).

22. See, e.g., Health Enhancement Research Org., *Membership*, HERO (2014), <http://hero-health.org/membership/>; *Our Story*, WELLNESS COUNCIL OF INDIANA, <http://www.wellnessindiana.org/about-us/> (last visited June 6, 2015); *WELCOA Overview*, WELLNESS COUNCIL OF AM., <https://www.welcoa.org/about/welcoa-overview/> (last visited August 16, 2015).

Kaiser Family Foundation survey of employers found that nearly three-quarters of all firms offering health benefits, and nearly all firms with 200 or more workers offering health benefits, offered at least one common type of wellness program.²³ While wellness programs can vary significantly in both structure and scope, many share common elements. For example, nearly two-thirds of large employers offered smoking cessation programs, nearly sixty percent offered lifestyle or behavioral coaching, and just under half offered weight-loss programs.²⁴ Just over half of large firms offered health risk assessments (HRAs), which typically involve a questionnaire that elicits information about an individual's health and health-related behaviors.²⁵ The HRA can then be used to evaluate the respondent's health risks.²⁶ A similar number offered biometric-screening programs for risk factors such as cholesterol or blood pressure.²⁷ Given that large firms account for more than half of U.S. employment, their programs could potentially impact a large number of Americans.²⁸

The nature of this impact remains in question. Advocates of wellness programs tout their potential for reducing costs and improving health. Advocates might point to a 2010 meta-analysis that found a \$3.27 drop in medical costs and a \$2.73 drop in absenteeism costs for every \$1 spent on wellness programs,²⁹ or one of a series of studies that have found impressive financial and health returns for individual wellness programs.³⁰ Many other studies, however, have found little impact or mixed results.³¹ A recent article

23. GARY CLAXTON ET AL., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2014 ANNUAL SURVEY 200 (2014), *available at* <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

24. *Id.* at 199.

25. *Id.* at 205.

26. *Id.*

27. *Id.*

28. ANTHONY CARUSO, U.S. CENSUS BUREAU, G12-SUSB 40, STATISTICS OF U.S. BUSINESSES EMPLOYMENT AND PAYROLL SUMMARY: 2012, at 1 (2015) (As of 2012, enterprises with more than 500 employees accounted for 51.6% of employment, while enterprises with 100 to 499 employees accounted for an additional 14.0% of employment).

29. See Katherine Baicker, David Cutler & Zirui Song, *Workplace Wellness Programs Can Generate Savings*, 29 HEALTH AFF. 304, 308 (2010).

30. See, e.g., Rachel M. Henke et al., *Recent Experience in Health Promotion at Johnson & Johnson: Lower Health Spending, Strong Return on Investment*, 30 HEALTH AFF. 490 (2011).

31. See, e.g., John P. Caloyer et al., *Managing Manifest Disease, but Not Health Risks, Saved PepsiCo Money over Seven Years*, 33 HEALTH AFF. 124 (2014) (finding that

based on a careful review of numerous studies raises doubts about the causal pathways by which wellness programs are commonly presumed to reduce costs, arguing that wellness programs' gains may arise from the shifting of costs to workers.³² Ultimately, wellness programs are difficult to evaluate in the aggregate, in part because of the difficulties of conducting rigorous evaluations in the employer setting.³³ Calls for further research in the wellness area are common.³⁴ The limited high-quality data available, however, have not dampened employer enthusiasm for the programs.

B. *Wellness Incentives*

One question that has attracted considerable interest among both employers and researchers is the extent to which the integration of financial incentives into wellness programs might increase program effectiveness. Some employees would undoubtedly participate in wellness activities simply because of the benefits they offer for health. Others, however, might require more motivation, and would be more likely to invest the necessary time, effort, and resources into participating if they knew that the investment would yield a financial return. The promise of \$100 or a discount or surcharge of \$100 on insurance premiums might make a difference.

Many employers have chosen to incorporate incentives into their program designs. The Kaiser Family Foundation 2014 survey suggests that among firms that provide wellness benefits, about 19% of all firms and 36% of large firms offer a financial incentive for participation.³⁵ About 24% of large firms offer incentives in the form

disease-management components of a wellness program reduced costs by \$136 per member per month, but that lifestyle-management components did not reduce costs); Gautam Gowrisankaran et al., *A Hospital System's Wellness Program Linked to Health Plan Enrollment Cut Hospitalizations but Not Overall Costs*, 32 HEALTH AFF. 477 (2013) (finding that participation in a wellness program decreased hospitalizations for targeted conditions but did not save money); Karen Chan Osilla et al., *Systematic Review of the Impact of Worksite Wellness Programs*, 18 AM. J. MANAGED CARE 68 (2012) (finding mixed results on wellness programs' impacts on health-related behaviors, substance use, physiologic markers, and cost).

32. Jill R. Horwitz et al., *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFF. 468 (2013).

33. For a discussion reviewing current research on wellness program and its impacts, see Kristin Madison, Harald Schmidt & Kevin G. Volpp, *Using Reporting Requirements to Improve Employer Wellness Incentives and Their Regulation*, 39 J. HEALTH POL. POL'Y & L. 1013, 1018–20 (2014).

34. See, e.g., *id.*; Baicker et al., *supra* note 29, at 304; Osilla et al., *supra* note 31, at 368.

35. CLAXTON, ET AL., *supra* note 23, at 203. A 2012 employer survey conducted by the RAND Corporation found that 69% of employers with wellness programs offered an incentive

of gift cards, cash, or rewards such as travel or merchandise, while 14% offer insurance premium discounts, and about 8% offer higher contributions to health reimbursement or health savings accounts.³⁶ About 12% of large firms offer incentives for completing their wellness programs, and about 32% of these firms offer incentives of at least \$500.³⁷ About 51% of large firms that offer HRAs provide financial incentives for their completion, and of these firms, about 36% offer incentives of \$500 or more.³⁸

Some incentive programs target not only HRA completion and program participation, but also smoking status and biometric outcomes such as blood pressure or body mass index. The Kaiser Family Foundation survey found that of the large firms surveyed that offered biometric screening, 8% reward or penalize employees based on screening results (other than those related to smoking).³⁹ A 2013–2014 survey completed by very large employers collectively employing more than 11 million individuals found that more than 40% of these employers rewarded nonsmokers or penalized smokers with an annual incentive averaging over \$500.⁴⁰ The survey also found that an additional 16% of employers plan to add incentives in 2015, a substantial increase over the levels that existed in 2011.⁴¹ In addition, more than 20% rewarded or penalized biometric outcomes such as weight or cholesterol levels, and a similar number of employers planned to adopt such incentives in 2015.⁴²

Do wellness incentives work? As is the case for wellness programs in general, the answer is unclear. Few studies attempt to isolate the impact of wellness incentives from other wellness program components. An analysis based on results from an employer survey conducted by the RAND Corporation suggests that incentives may increase HRA completion rates and perhaps program participation.⁴³

in connection with at least one program. SOEREN MATTKE ET AL., WORKPLACE WELLNESS PROGRAMS STUDY: FINAL REPORT 70 (2013).

36. CLAXTON, ET AL., *supra* note 23, at 203.

37. *Id.* at 204.

38. *Id.* at 206.

39. *Id.* at 207.

40. TOWERS WATSON & NAT'L BUS. GRP ON HEALTH, THE NEW HEALTH CARE IMPERATIVE: DRIVING PERFORMANCE, CONNECTING TO VALUE 5, 21 (2014). All employers surveyed employed at least one thousand employees, *id.* at 5.

41. *Id.* at 22.

42. *Id.*

43. MATTKE ET AL., *supra* note 35, at 107–08. A follow-up study found that comprehensive wellness programs without incentives elicited participation from 52% of

Randomized controlled trials demonstrate that appropriately structured financial incentives can help individuals achieve health goals such as quitting smoking or losing weight, but there is a need for more evidence on the impact of health plan-based wellness incentives such as premium adjustments.⁴⁴

The limited information available about the impact of wellness incentives is especially troubling in light of the potential concerns that incentive-based programs may raise. Incentives that improve health, increase productivity, and reduce health care costs could help both employers and employees; if net gains exist and are shared through premium reductions, benefit enhancements, or wage increases, they could even benefit employees who do not respond to the incentives. At the same time, incentive-based programs offer no health benefits to, and can impose significant financial burdens on, employees who do not engage in the targeted activities or who fail to achieve the targeted outcomes. These burdens will fall particularly heavily on low-income individuals, and will tend to fall disproportionately on those who face health-related or other barriers to program engagement. The tensions inherent in wellness incentives—their potential for generating health-related benefits and burdens simultaneously—pose challenges for regulators trying to achieve a complex mix of policy objectives.

II. FEDERAL REGULATION UNDER HIPAA AND THE ACA

There is no federal statute that imposes a broad ban on discrimination on the basis of health. Instead, more narrowly focused statutes prohibit certain types of entities from engaging in certain types of health-related discrimination. Two statutes adopted in the 1990s, the ADA and HIPAA, provide much of the foundation for federal protections against health-based discrimination in the workplace. Title I of the ADA prohibits employment discrimination on the basis of disability,⁴⁵ a category that significantly overlaps with

employees, while programs that offered incentives framed as rewards elicited 56% participation and incentives framed as penalties elicited 71% participation. SOEREN MATTKE ET AL., *WORKPLACE WELLNESS PROGRAMS: SERVICES OFFERED, PARTICIPATION, AND INCENTIVES*, at xiii (2014).

44. See Kevin G. Volpp et al., *A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation*, 360 *NEW ENG. J. MED.* 699 (2009); Scott D. Halpern, *Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation*, 372 *NEW ENG. J. MED.* 2108 (2015); and studies cited in Madison, Schmidt & Volpp, *supra* note 33, at 1014–15.

45. See discussion *infra* Part III.

but is not coextensive with health. Similarly, HIPAA does not prohibit employers from discriminating on the basis of health, but instead prohibits health status-based discrimination in group health plans.⁴⁶ More specifically, HIPAA prohibits discrimination based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability,⁴⁷ including through higher premiums or contributions.⁴⁸

As described in Part I, corporate wellness programs were already well established at the time of HIPAA's enactment. Many of these programs targeted individuals with specific health conditions, such as high blood pressure, or behaviors or activities having some link to health status or disability. At least some of these programs made use of financial incentives. A 1987 journal article noted that all wellness programs were voluntary but that "some use incentives (from T-shirts to cash) to encourage participation."⁴⁹ A 1989 magazine article profiled a company that provided exercise facilities and offered "a check for \$250 to employees who exercise four days a week from January to June."⁵⁰ A 1992 magazine article highlighted corporate health incentives such as a "\$10 monthly rebate on health insurance to employees who participate in a health-risk screening and fall within acceptable guidelines," although "demonstrated willingness to change qualifies [the employees] for the rebate."⁵¹ Other examples included monthly insurance surcharges of \$10 for smokers, a \$5 monthly contribution for employees "who smoke or who are severely overweight or underweight," and a pilot program that involved both monthly discounts and surcharges in the range of \$2 to \$32 tied to tobacco use, blood pressure, cholesterol, exercise, and weight.⁵²

The use of incentives was not necessarily widespread in the pre-HIPAA era. Early discussions of these programs focus on the fact

46. 29 U.S.C. § 1182 (2013).

47. *Id.* § 1182(a)(1)(A)–(H).

48. *Id.* § 1182(b); 29 C.F.R. § 2590.702(a), (c)(1) (2015).

49. Conrad, *supra* note 9, at 256.

50. Roberts & Harris, *supra* note 16, at 55. The program reportedly paid \$250 for smoking cessation and \$5 for each pound lost, but then required individuals receiving the incentives to donate double these amounts if they started smoking again or regained lost weight.

51. Shari Caudron, *Are Health Incentives Disincentives?*, PERSONNEL J., Aug. 1992, at 34, 35.

52. *Id.* at 35–37.

that the programs were offered, not on the financial incentives embedded within them. This suggests that such incentives were not the dominant features of these programs. Indeed, early articles on wellness programs frequently reference whether the wellness services were free or whether there was a charge for an employee who wished to enroll in a wellness course or exercise program.⁵³ Moreover, the same 1992 article that described incentive programs also reported that a benefits consulting firm survey of very large employers found that only 3% offered rewards.⁵⁴ Nevertheless, it was clear that some employers had embraced incentives and that others were contemplating them; the survey indicated that 9% of employers planned to introduce incentives by the end of the year, and that 19% were considering doing so.⁵⁵

Some of the incentives in place by the mid-1990s involved insurance premium adjustments based on health status, and HIPAA's provisions prohibiting discrimination within health plans had the potential to disrupt these programs. Congress chose to permit the continued use of wellness incentives in the health plan context, however, through a statutory exception for "establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention."⁵⁶ Final HIPAA regulations issued in 2006 established the requirements that incentives would need to meet to fall within the exception.⁵⁷ One of the requirements was that a health plan's wellness incentives could not exceed 20% of the total cost of coverage (including both employee and employer contributions) in order to "avoid a reward or penalty being so large as to have the effect of denying coverage or creating too heavy a financial penalty on individuals who do not satisfy an initial wellness program standard that is related to a health factor."⁵⁸

53. See Roberts & Harris, *supra* note 16, at 46 (referring to "[s]pecial exercise classes, which cost \$20 or less"); *id.* (stating that for some courses, "costs depend on the facilities and resources required"); *id.* at 58 (referring to courses "costing from \$5 to \$50, on stress management, smoking cessation, fitness and nutrition").

54. Caudron, *supra* note 51, at 35.

55. *Id.*

56. 29 U.S.C. § 1182(b)(2)(B).

57. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,018 (Dec. 13, 2006) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 146).

58. *Id.*

Most of the ACA's provisions mirror the HIPAA regulations.⁵⁹ The ACA permits premium discounts, premium surcharges, and other plan-based, health status-related incentives for programs that are "reasonably designed to promote health or prevent disease" and are "not a subterfuge for discriminating based on a health status factor."⁶⁰ The rewards must be offered annually,⁶¹ and must be available to all similarly situated individuals.⁶² Programs must grant a waiver or recognize a reasonable alternative standard for individuals for whom "it is unreasonably difficult due to a medical condition to satisfy" or "medically inadvisable to attempt to satisfy" a wellness program standard.⁶³ All plan materials describing the wellness program must disclose the availability of the reasonable alternative standard or waiver.⁶⁴ Regulations issued in 2013 sought to increase the likelihood that health-contingent wellness programs supported enrollees in their efforts to improve health, rather than merely shifting costs to higher risk individuals,⁶⁵ by clarifying what constitutes a reasonable alternative standard.⁶⁶ Several provisions were aimed at limiting the burden on individuals invoking such standards. For example, a provision requires employers to assist in identifying a program that would satisfy the standard and mandated that any time commitment involved be reasonable.⁶⁷

One respect in which the ACA's requirements deviated from HIPAA's requirements was in the permissible magnitude of incentives. Policymakers decided to reaffirm their commitment to incentive-based wellness programs by raising the ceiling on health-contingent incentives from 20% to 30% of the cost of coverage, while

59. Affordable Care Act § 1201, codified at 42 U.S.C. § 300gg-4(j) (2010). For a discussion of these rules, see Kristin M. Madison, Kevin G. Volpp, and Scott D. Halpern, *The Law, Policy, and Ethics of Employers' Use of Financial Incentives to Improve Health*, 39 J.L. MED. & ETHICS. 450, 461–63 (2011) (discussing the ACA's limits on wellness programs). See also Lindsay F. Wiley, *Access to Health Care as an Incentive for Healthy Behavior? An Assessment of the Affordable Care Act's Personal Responsibility for Wellness Programs*, 11 IND. HEALTH L. REV. 635, 666–91 (2014).

60. 42 U.S.C. § 300gg-4(j)(3)(B) (2013).

61. *Id.* § 300gg-4(j)(3)(C).

62. *Id.* § 300gg-4(j)(3)(D).

63. *Id.* § 300gg-4(j)(3)(D)(i).

64. *Id.* § 300gg-4(j)(3)(E).

65. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 Fed. Reg. 70,619, 70,624, 70,629 (Nov. 26, 2012).

66. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,163–66.

67. Treas. Reg. § 54.9802-1(f)(3)(iv)(C) (2014).

giving regulators the authority to further increase the limit to 50%.⁶⁸ Regulators decided to leave the 30% ceiling in place for wellness programs in general, but permitted plans to increase this ceiling “by an additional 20 percentage points (to 50 percent), to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.”⁶⁹ With average total premiums for employer-sponsored coverage for individuals now exceeding \$6,000, these ceilings accommodate sizeable incentives.⁷⁰ For example, an employer could impose a \$3,000 premium surcharge on smokers, or, alternatively, institute a program that offered annual \$500 premium rebates for reaching body mass index and cholesterol targets, plus a \$2,000 premium discount for being a nonsmoker.

In theory, employers could institute wellness programs with incentives that significantly exceeded these amounts. While the ceiling applies to the sum of rewards and penalties for health-contingent wellness programs that impact health plan benefits, premiums, or contributions, not all wellness incentives are health contingent, and not all incentives are offered through health plans. The limit applies when a program “requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward).”⁷¹ Health-contingent programs include both activity-based programs, such as walking programs, for which health factors (such as asthma) might impede the ability to obtain a reward, and outcome-based programs, such as rewards for someone who meets a blood pressure target.⁷² The limit does not apply to rewards based solely on participation and not linked to health, such as a subsidy for a fitness membership or a reward for taking a class, participation in a smoking cessation program, undergoing diagnostic testing, or completing an HRA questionnaire.⁷³

Moreover, the limit can only apply when incentives are linked to employees’ health plans. These statutory and regulatory limits did not arise out of a general desire to limit employer involvement in

68. 42 U.S.C. § 300gg-4(j)(3)(A).

69. Treas. Reg. § 54.9802-1(f)(5)(i).

70. CLAXTON, ET AL., *supra* note 23, at 2.

71. Treas. Reg. § 54.9802-1(f)(1)(iii).

72. Treas. Reg. § 54.9802-1(f)(1)(iv) (defining activity-only wellness programs); *id.* § 54.9802-1(f)(1)(v) (defining outcome-based wellness programs).

73. Treas. Reg. § 54.9802-1(f)(1)(ii) (defining participatory wellness programs).

wellness or a general policy objective of weakening the link between health status and finances. They arose out of a commitment to nondiscrimination in group health plans, as reflected in HIPAA and the ACA, and a simultaneous desire to permit incentive-based health promotion programs that might sometimes come into conflict with this commitment. Because the purpose of the rules is to give shape to an exception to a prohibition on discrimination in health plans, the rules focus on health plan-based incentives.⁷⁴ The 2014 Kaiser Family Foundation survey suggests that 75% of smaller firms provide most of their wellness benefits through their health plans, while only 55% of firms with 200 or more employees do.⁷⁵ The 2012 RAND Employer Survey found that nearly 70% of all employers offering wellness incentives gave them to employees directly, while just over 50% provided them through health plans.⁷⁶ The RAND survey also found that results-based wellness programs focusing on weight tend to be administered by health plans, while those focusing on smoking tend to be more evenly split, with a slightly higher percentage of health plan-administered rather than employer-administered programs.⁷⁷

III. DISABILITY AND WORKPLACE WELLNESS

As the previous section's discussion of the HIPAA-ACA regulatory framework demonstrates, regulators have devoted considerable attention to the tensions between wellness incentives and a commitment to avoiding health-based discrimination in health insurance. Regulators have devoted much less attention to the tensions between wellness incentives and a commitment to avoiding disability-based discrimination in employment. While HIPAA prohibits health factor-based (including disability-based) discrimination in health insurance, Title I of the ADA prohibits disability-based discrimination in employment. It applies to employers with fifteen or more employees and states that "[n]o covered entity shall discriminate against a qualified individual on the basis of disability in regard to . . . employee compensation, job

74. The regulation describes the relevant rewards as rewards for "health-contingent wellness programs with respect to the plan." Treas. Reg. § 54.9802-1(f)(3)(ii); *id.* § 54.9802-1(f)(4)(ii).

75. CLAXTON, ET AL., *supra* note 23, at 196.

76. MATTKE ET AL., *supra* note 35, at xxi.

77. *Id.* at xxii., Figure S.6.

training, and other terms, conditions, and privileges of employment.”⁷⁸ Workplace wellness programs are therefore subject to the ADA’s reach.

A. Individuals with Disabilities in an Era of Workplace Wellness

Individuals with disabilities can benefit from workplace wellness programs. Having a “physical or mental impairment that substantially limits one or more major life activities” might not preclude participation in a walking program, meeting a blood pressure target, or quitting smoking,⁷⁹ and engagement with wellness programs that include these elements might improve individuals’ health. *The Surgeon General’s Call to Action to Improve the Health and Wellness of Persons with Disabilities*, a 2005 report, emphasized that “[p]ersons with disabilities can promote their own good health by developing and maintaining healthy lifestyles.”⁸⁰ Federal agencies have promoted the inclusion of individuals with disabilities in worksite wellness programs and have commissioned research on the topic.⁸¹ To the extent that wellness programs are viewed as a toolkit that empowers individuals⁸² by supporting their efforts to improve their own health, wellness programs can benefit individuals with disabilities just as they benefit individuals without disabilities.

Wellness programs are not always viewed as empowering, however. One scholar has suggested that the focus on individual responsibility for health “creates new ‘health deviants’ and

78. See 42 U.S.C. § 12111(2) (2013) (defining “covered entity”); *id.* § 12111(5) (defining “employer”); *id.* § 12112(a).

79. According to 42 U.S.C. § 12102, “[t]he term ‘disability’ means, with respect to an individual (A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment (as described in paragraph (3)).”

80. U.S. DEP’T OF HEALTH & HUMAN SERVS., *THE SURGEON GENERAL’S CALL TO ACTION TO IMPROVE THE HEALTH AND WELLNESS OF PERSONS WITH DISABILITIES* 21 (2005), available at http://www.ncbi.nlm.nih.gov/books/NBK44667/pdf/Bookshelf_NBK44667.pdf.

81. OFFICE OF DISABILITY EMP’T POLICY, U.S. DEP’T OF LABOR, *RETAINING EMPLOYEES IN YOUR WORKSITE WELLNESS PROGRAM* 5 (2009), available at <http://www.dol.gov/odep/research/WellnessToolkit.pdf>; CATHERINE CALL, ROBYN GERDEN & KRISTEN ROBINSON, *HEALTH & WELLNESS RESEARCH STUDY: CORPORATE AND WORKSITE WELLNESS PROGRAMS: A RESEARCH REVIEW FOCUSED ON INDIVIDUALS WITH DISABILITIES* 6 (2009), available at <http://www.dol.gov/odep/research/CorporateWellnessResearchLiteratureReview.pdf>.

82. See Conrad, *supra* note 9, at 264 (discussing the potential for individual empowerment within the context of wellness programs).

stigmatizes individuals for certain unhealthy lifestyles” and can lead to “victim-blaming responses,” even when factors beyond individuals’ control may contribute to a failure to meet program objectives.⁸³ The focus on individuals diverts attention from institutions and organizations that could intervene in ways that improve health, perhaps with better results than incentive-based wellness programs could ever deliver.⁸⁴ In a recent article, Carrie Basas argues that “wellness programs institutionalize disability bias and a false perception of health attainability,” and that “[t]he wellness imperative also shifts the attention from societal barriers to health, discrimination based on perceived unhealthy states, and inequitable resource allocation to personal improvement and paternalistic intervention.”⁸⁵ She concludes that the “fundamental tension between wellness and disability rights remains that of bodily enhancement and perfection versus acceptance and inclusion.”⁸⁶

Wellness programs can create risks for individuals with disabilities, just as they can for individuals with other kinds of health issues. Disabilities can impede individuals’ abilities to obtain the rewards that incentive programs offer,⁸⁷ which would redistribute resources away from individuals with disabilities to others in the workplace. Because wellness programs often involve eliciting information related to disabilities, wellness programs could also focus employers’ attention on employees’ disabilities. An HRA, for example, can involve many questions that reveal disabilities about which an employer might otherwise be unaware. Access to this data could increase the potential for disability-related discrimination within the workplace, especially if managers or other workers can

83. *Id.* at 267–68 (discussing “moralizing health concerns” as a potential “pitfall” of wellness programs).

84. *See, e.g.,* Carlos Castillo-Salgado, *Assessing Recent Development and Opportunities in the Promotion of Health in the American Workplace*, 19 SOC. SCI. & MED. 349 (1984) (contrasting “individual-based lifestyle approach” and “environmental-social approach” to workplace health promotion); *cf.* Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 U.C. DAVIS L. REV. 121, 122 (2013) (discussing personal responsibility and stigmatization of fatness, and arguing that “interventions targeting unhealthy products and environments must take precedence over interventions targeting obese individuals.”).

85. Carrie Griffin Basas, *What’s Bad about Wellness? What the Disability Rights Perspective Offers about the Limitations of Wellness*, 39 J. HEALTH POL. POL’Y & L. 1035, 1035, 1052 (2014).

86. *Id.* at 1060.

87. *Cf. id.* at 1052 (“[The focus on wellness] pushes for individual responsibility and ascribed models of being that do not fit everyone and are not even possible in many situations because of constrained resources and energy.”).

easily access other individuals' data.⁸⁸ Given the risks that wellness programs can introduce into the workplace, the ADA provides important protections for individuals exposed to these programs.

B. The Americans with Disabilities Act

The broad reach of the ADA in the employment context ensures its applicability to wellness programs. For example, the ADA reinforces the ACA reasonable alternative standard rules in the disability context by requiring employers to provide reasonable accommodations that would allow employees with disabilities to take full advantage of employee wellness programs, including the opportunities to earn rewards or avoid penalties.⁸⁹ In some cases, obligations under the ADA extend beyond those of the ACA. For example, in recently proposed regulations the EEOC points out that an employer offering an incentive to attend a nutrition class “would have to provide a sign language interpreter so that an employee who is deaf and needs an interpreter to understand the information communicated in the class could earn the incentive, as long as providing the interpreter would not result in undue hardship to the employer.”⁹⁰ Such a requirement would seem to be a relatively straightforward application of the ADA to the wellness program context.

One application of the ADA to wellness programs, however, has proved to be far from straightforward. A provision of the ADA states that a “covered entity shall not require a medical examination and shall not make inquiries of an employee as 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-

88. The EEOC's proposed rule contains an extensive discussion of employer confidentiality obligations. It notes that “[a]s a best practice, individuals who handle medical information that is part of an employee health program should not be responsible for making decisions related to employment, such as hiring, termination, or discipline.” Amendments to Regulations Under the Americans with Disabilities Act, 80 Fed. Reg. 21,659, 21,669 (proposed Apr. 20, 2015) (to be codified at 29 C.F.R. pt. 1630) [hereinafter ADA Proposed Rule].

89. See 42 U.S.C. § 12112(b)(5)(A) (2013) (mandating reasonable accommodations); 29 C.F.R. § 1630.2(o)(1)(iii) (defining reasonable accommodation to include adjustments to enable “equal benefits and privileges of employment”); ADA Proposed Rule, *supra* note 88, at 21,664 (mentioning that reasonable accommodations must be provided in the context of health programs).

90. ADA Proposed Rule, *supra* note 88, at 21,668.

related and consistent with business necessity.”⁹¹ Legislative history for this provision emphasizes that “inquiry or medical examination that is not job-related serves no legitimate employer purpose, but simply serves to stigmatize the person with a disability.”⁹² A House Report mentions the existence of “widespread irrational prejudice against persons with cancer,” and notes that the “individual with cancer may object merely to being identified, independent of the consequences,” since being identified “often carries both blatant and subtle stigma.”⁹³

The kinds of testing and questionnaires often involved in wellness programs would not likely be considered job related and consistent with business necessity. If there were no applicable exception, then these tests and questionnaires could potentially be prohibited under this ADA provision. As discussed in Part I, however, by the time that the ADA was enacted in 1990, employer-sponsored wellness programs were already quite common, especially among large employers. By the late 1980s, nearly 30% of worksites reported that they conducted health risk assessments either through questionnaires or physical exams, such as blood pressure screening, cancer screening, cholesterol tests, blood sugar tests, or fitness tests.⁹⁴ The House Report notes the trend toward employers offering “voluntary wellness programs” that include medical screening. It states that “[a]s 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 or of preventing occupational advancement, these activities would fall within the purview of accepted activities.”⁹⁵ To permit these activities in light of the general prohibition on examinations and inquiries, the ADA allows employers to “conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program.”⁹⁶

The ADA does not, however, define the term “voluntary” as applied to examinations or histories, which raises a number of important questions. Is a medical examination voluntary if it is

91. 42 U.S.C. § 12112(d)(4)(A).

92. H.R. REP. NO. 101-485, pt. 2, at 75 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 358.

93. *Id.*

94. Jonathan E. Fielding, *Frequency of Health Risk Assessment Activities at U.S. Worksites*, 5 AM. J. PREVENTIVE MED. 73 (1989).

95. H.R. REP. NO. 101-485, at 75.

96. 42 U.S.C. § 12112(d)(4)(B).

required for participation in a particular employer benefit program? Is a medical history voluntary if an employee is financially rewarded for completing it? What if an employee is subject to an insurance premium surcharge if the employee refuses to complete a questionnaire? As Part I makes clear, at the time the ADA was enacted, financial incentives had already begun to find their way into health programs. The extent to which these incentives were associated with disability-related questionnaires or medical examinations is much less clear, however, and neither the ADA nor the House Report references the use of incentives.

In 2000, the EEOC issued enforcement guidance that clarified that employers can make disability-related inquiries or conduct medical examinations as part of a voluntary wellness program if “medical records acquired as part of the wellness program are kept confidential and separate from personnel records.”⁹⁷ It further explained that a “wellness program is ‘voluntary’ as long as an employer neither requires participation nor penalizes employees who do not participate.”⁹⁸ It gave no further clarification, however, of the kinds of sanctions that would render the program involuntary. For example, would a failure to earn a reward constitute an impermissible penalty? And does the answer to this question depend on the size of the reward?

In 2009, there was a hint that the size of the incentive might matter. In 2008, a county wrote the EEOC, asking whether it would be permissible to condition participation in a county health plan on participation in a health risk assessment program.⁹⁹ In 2009, legal counsel for the EEOC issued a letter stating that the loss of opportunity to participate in a health plan would render the program involuntary, and therefore violate the ADA.¹⁰⁰ The same letter then suggested that inducements to answer disability-related inquiries or engage in medical examinations would be permissible if they remained under twenty percent of the cost of insurance coverage, consistent with the ceiling imposed by the 2006 final HIPAA

97. *Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act*, U.S. EQUAL EMP. OPPORTUNITY COMMISSION (July 27, 2000) [hereinafter *Enforcement Guidance*], available at <http://www.eeoc.gov/policy/docs/guidance-inquiries.html>.

98. *Id.*

99. Peggy R. Mastroianni, U.S. EQUAL EMP. OPPORTUNITY COMMISSION (Mar. 6, 2009), http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.

100. *Id.*

regulations.¹⁰¹ Two months later, however, EEOC legal counsel rescinded this portion of the letter, explaining that its correspondent's initial inquiry had not asked about permissible levels of inducement, and that the "Commission is continuing to examine" the question.¹⁰²

The EEOC was apparently still continuing to examine the question over a year later, as it had not yet issued any formal guidance answering the question when it addressed a similar question under a different antidiscrimination statute, the Genetic Information Nondiscrimination Act (GINA).¹⁰³ The statute made it unlawful for an employer to request genetic information with respect to an employee or an employee's family member, but provided an exception for "health or genetic services" that "are offered by the employer, including such services offered as part of a wellness program" where "the employee provides prior, knowing, voluntary, and written authorization."¹⁰⁴ In promulgating final regulations under GINA in 2010, the EEOC restricted the applicability of the exception to situations where "[t]he provision of genetic information by the individual is voluntary, meaning the covered entity neither requires the individual to provide genetic information nor penalizes those who choose not to provide it."¹⁰⁵ The regulations subsequently state that employers can offer inducements to complete HRAs that request genetic information, "provided that the covered entity makes clear . . . that the inducement will be made available whether or not the participant answers questions regarding genetic information."¹⁰⁶ In short, no incentives may be offered with respect to genetic information, an approach quite different from the one suggested in the retracted portion of the 2009 letter.¹⁰⁷

In 2013, the Department of Treasury, the Department of Labor, and the Department of Health and Human Services released the final regulations governing wellness programs under the ACA.¹⁰⁸ The ACA promoted growth in wellness incentives in many ways; in

101. *Id.*

102. *Id.*

103. Regulations Under the Genetic Information Nondiscrimination Act of 2008, 75 Fed. Reg. 68,911 (Nov. 9, 2010) (to be codified at 29 C.F.R. pt. 1635).

104. 42 U.S.C. § 2000ff-1(b) (2008).

105. 29 C.F.R. §1635.8(b)(2)(i) (2011).

106. *Id.*

107. For a discussion of the tensions between wellness programs and genetic privacy, as well as an overview of the GINA regulations, see generally Bard, *supra* note 3.

108. Incentives for Nondiscriminatory Wellness Programs, *supra* note 65.

addition to lifting the wellness incentive ceiling, the ACA called for information to be gathered on wellness programs and mandated wellness demonstration projects within both Medicaid and the individual insurance marketplace.¹⁰⁹ Some employers might have been reluctant to adopt wellness programs, however, given the continued uncertainty about the applicability of the ADA. This uncertainty remained unresolved in the aftermath of the release of the ACA rules. In the rules, the Departments simply “reiterate[d] that compliance with these final regulations is not determinative of compliance with any other applicable requirements,”¹¹⁰ and the EEOC still had not released a formal rule on the issue.

C. *Litigation, Legislation, Regulation*

In fall 2014, the EEOC brought three suits against three employers based on their wellness programs.¹¹¹ One of these employers was Honeywell, a company with more than 127,000 employees that had wellness programs involving testing for cholesterol and blood pressure as of the 1980s.¹¹² The EEOC’s petition alleged that Honeywell had announced that employees “are to undergo biometric testing by a Honeywell vendor for the 2015 health benefit year,” including for blood pressure, cholesterol, glucose, body mass index, and nicotine or cotinine (an indicator of tobacco exposure).¹¹³ It further alleged that if employees did not take biometric tests, they would lose a company contribution of up to \$1,500 to their health savings accounts and be subject to a \$500 medical plan surcharge and a \$1,000 tobacco surcharge.¹¹⁴ The petition then alleged that the biometric testing constituted a medical

109. See Kristin Madison, Harald Schmidt & Kevin G. Volpp, *Smoking, Obesity, Health Insurance, and Health Incentives in the Affordable Care Act*, 310 JAMA 143, 143–44 (describing ACA’s wellness provisions); see also Bard, *supra* note 3, at 475–76.

110. Incentives for Nondiscriminatory Wellness Programs, *supra* note 65, at 33,168.

111. Petition for Plaintiff, Equal Emp’t Opportunity Comm’n v. Honeywell Int’l, Inc., No. 0:14-CV-04517 (D. Minn. 2014) [hereinafter EEOC’s Petition]; Press Release, Equal Emp’t Opportunity Comm’n, EEOC Lawsuit Challenges Flambeau Over Wellness Program (Oct. 1, 2014) (<http://www.eeoc.gov/eeoc/newsroom/release/10-1-14b.cfm>); Press Release, Equal Emp’t 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>).

112. *Our Company*, HONEYWELL, <http://honeywell.com/About/Pages/our-company.aspx> (last visited June 27, 2015); Roberts & Harris, *supra* note 16, at 58.

113. EEOC’s Petition, *supra* note 111, ¶¶ 10–13.

114. *Id.* ¶ 14.

examination under the ADA that was not job-related or consistent with business necessity, that Honeywell “imposes a penalty upon employees to make them participate,” that the testing was not voluntary, and that the exam was an unlawful medical examination in violation of the ADA.¹¹⁵

The reaction from the business community was swift. Within a few days after the court filing, the ERISA Industry Council (ERIC), an organization “advocating for the employee benefit and compensation interests of the country’s largest employers,”¹¹⁶ called the suit an “outrageous development,” expressed concern “that it apparently is no longer enough for an employer-sponsored wellness plan to comply with the applicable requirements under the Affordable Care Act,” and noted that ERIC had been “working on this issue for the last several years” seeking “clear rules explaining how the ADA applies to workplace wellness programs.”¹¹⁷ Within several weeks of the court filing, the Business Roundtable, which has members that supply coverage to over 40 million Americans, sent a letter to the federal regulators responsible for the ACA regulations.¹¹⁸ The letter extolled the virtues of wellness programs that identify health risk factors and stated that “[i]f employers believe that complying with the letter of the law can still result in enforcement actions, it will send a chilling effect across the country,” and that “[w]e do not want to see the kinds of actions taken by the EEOC undermine law and negate the benefits of these plans.”¹¹⁹

In November 2014, in an opinion that highlighted the “intriguing legal questions” raised in the case,¹²⁰ the federal district court denied the EEOC’s motion for a preliminary injunction to prevent Honeywell from imposing penalties, finding that the EEOC did not establish a threat of irreparable harm, and that the balance of harms favored

115. *Id.* ¶¶ 28–33. The EEOC’s Petition also made allegations with respect to the involvement of employee spouses and claims related to GINA; these topics are beyond the scope of this essay. *Id.* ¶¶ 14, 34–39.

116. The ERISA Indus. Comm., *About ERIC*, ERISA INDUSTRY COMMITTEE, <http://www.eric.org/about/> (last visited July 3, 2015).

117. Press Release, ERIC Outraged over Latest Wellness Suit Brought by EEOC (Oct. 29, 2014), <http://www.eric.org/health/eric-outraged-over-latest-wellness-suit-brought-by-eeoc>.

118. John Engler, *Letter to Secretaries Burwell, Lew, and Perez*, BUS. ROUNDTABLE 1 (Nov. 14, 2014), <http://businessroundtable.org/sites/default/files/letters/2014%2011%2014%20Engler%20Burwell%20Lew%20Perez%20EEOC%20%282%29.pdf>.

119. *Id.*

120. *Equal Emp’t Opportunity Comm’n v. Honeywell Int’l, Inc.*, No 0:14-CV-04517, slip op. at 4 (D. Minn. Nov. 6, 2014).

Honeywell.¹²¹

The court ruling did not end discussions of wellness programs and the potential impact of the ADA, however. In January 2015, the U.S. Senate Committee on Health, Education, Labor & Pensions held a committee hearing titled “Employer Wellness Programs: Better Health Outcomes and Lower Costs.”¹²² In March 2015, the “Preserving Employee Wellness Programs Act” was introduced into Congress. Section 3(a) of the Act states that:

Notwithstanding any other provision of law, workplace wellness programs, or programs of health promotion or disease prevention offered by an employer or in conjunction with an employer-sponsored health plan . . . shall not violate the Americans with Disabilities Act of 1990 . . . because such program provides any amount or type of reward . . . to program participants if such program complies with such section 2705(j) (or any regulations promulgated with respect to such section by the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury).¹²³

Under this provision, if health plan-based wellness incentives were structured to comply with the ACA’s rules on incentives, they would not violate the ADA.

Then in April 2015, the EEOC issued a proposed rule that was intended to clarify the application of ADA’s Title I to employer-sponsored wellness programs.¹²⁴ The proposed rule lays out the conditions under which medical examinations and inquiries are permissible under the ADA’s exception for voluntary employee health programs. Like the ACA’s regulations, the ADA proposed rule requires that employee health programs be reasonably designed to promote health or prevent disease.¹²⁵ The rule proposes interpretive guidance that explains that a program is not reasonably designed if it requires “an overly burdensome amount of time for participation, requires unreasonably intrusive procedures, or places significant costs

121. *Id.* at 2–4.

122. *Employer Wellness Programs: Better Health Outcomes and Lower Costs: Hearing Before the U.S. S. Comm. on Health, Educ., Labor & Pensions*, 114th Cong. (2015).

123. Preserving Employee Wellness Programs Act, H.R. 1189, 114th Cong. § 3(a) (2015).

124. ADA Proposed Rule, *supra* note 88.

125. *Id.* at 21,667 (proposing 29 C.F.R. § 1630.14(d)(1)).

related to medical examinations on employees,” or if it “exists mainly to shift costs from the covered entity to targeted employees based on their health.”¹²⁶

To be voluntary, programs cannot require employees to participate, tie coverage or a particular benefit package to participation, or “take any adverse employment action or retaliate against, interfere with, coerce, intimidate, or threaten employees.”¹²⁷ Voluntariness also requires that with respect to wellness programs that are part of group health plans, employees must receive notices related to the handling of the employee’s medical information.¹²⁸ A subsequent provision of the proposed regulation stipulates that information obtained through a wellness program can be provided to the ADA-covered entity only in aggregate terms.¹²⁹

Finally, the proposed rule limits the magnitude of wellness incentives that are part of a group health plan:

The use of incentives (financial or in-kind) in an employee wellness program, whether in the form of a reward or penalty, together with the reward for any other wellness program that is offered as part of a group health plan . . . will not render the program involuntary if the maximum allowable incentive available under the program (whether the program is a participatory program or a health-contingent program, or some combination of the two . . .) does not exceed 30 percent of the total cost of employee-only coverage.¹³⁰

As the interpretive guidance explains, this rule means that if a group health plan offers a reward for HRA completion and a health-contingent reward to promote cardiovascular health, the two incentives must be added together and then compared against the thirty-percent-of-the-cost-of-coverage threshold to determine whether the HRA’s disability-related inquiries are permissible under the ADA.¹³¹ Wellness programs that do not rely on disability-related inquiries or medical examinations, such as programs involving rewards for attending smoking cessation classes, are not subject to the

126. *Id.* at 21,668.

127. *Id.* at 21,667 (proposing 29 C.F.R. § 1630.14(d)(2)(i)–(iii)).

128. *Id.* (proposing 29 C.F.R. § 1630.14(d)(2)(iv)).

129. *Id.* (proposing 29 C.F.R. § 1630.14(d)(6)).

130. *Id.* (proposing 29 C.F.R. § 1630.14(d)(3)).

131. *Id.* at 21,668.

ADA incentive rules.¹³² The applicability of the proposed rule's incentive limits to rewards or penalties based on tobacco use would therefore depend on the mechanism for determining use. A reward contingent on a negative result on a biometric screening for nicotine would be subject to the ADA limit of thirty percent. By contrast, a reward contingent on a negative answer to a question about nicotine use would not be subject to the ADA limit, assuming that the question is not a disability-related inquiry.¹³³

D. The ADA, the ACA, and Wellness Programs: Acknowledging the Policy Tensions

The events over the past year highlight the tensions inherent in policymakers' efforts to achieve multiple goals simultaneously. HIPAA and the ACA reflect a desire to increase access to affordable health insurance by curtailing health status-based insurance discrimination.¹³⁴ The HIPAA-ACA wellness program exceptions reflect a willingness to limit the reach of antidiscrimination principles in order to support employer wellness programs that have long been touted as tools for improving health, containing costs, increasing morale, and boosting productivity.¹³⁵ The ADA's limit on disability-related inquiries and medical examinations reflects a goal of combating disability-related stigma in the workplace against the backdrop of a larger aim of promoting equality of opportunity and economic self-sufficiency by prohibiting disability-based discrimination.¹³⁶ The voluntariness exception to this limit, like the HIPAA-ACA wellness program exception, reflects a willingness to support, or at least accommodate, employers' efforts to promote health. Thus, when read together, HIPAA, the ACA, and the ADA imply that policymakers would like to limit health-based discrimination in health insurance, reduce disability-related discrimination in employment, and facilitate employers' continued efforts to engage with employees on health-related issues. These goals suggest that policymakers' broader objectives are improving health, increasing economic opportunity, and enhancing workplace

132. *Id.*

133. *Id.* at 21,669.

134. See discussion *supra* Part II.

135. See discussion *supra* Parts I.A, II.

136. See 42 U.S.C. § 12101(a)(7) (2013) (listing the "Nation's proper goals" for individuals with disabilities); *id.* § 12101(b)(1) (describing the statute's purpose as the elimination of discrimination against individuals with disabilities).

efficiency.

The policy mechanisms for achieving these goals sometimes come into conflict, as policymakers recognized early on. By carving out exceptions to antidiscrimination statutes, policymakers implicitly acknowledged the discrimination concerns associated with wellness programs. The past year's events, however, have brought policy tensions to the fore, focusing attention on the following question: Could wellness incentives that policymakers have deemed acceptable from a HIPAA-ACA perspective nonetheless turn out to be unacceptable, given their implications for achieving the ADA's objectives? In bringing the Honeywell suit, the EEOC indicated that the answer might be yes, but by proposing the Preserving Employee Wellness Programs Act, some current legislators indicated that the answer should be no.

The EEOC's proposed ADA rule declines to give a simple yes-or-no answer to this question. The proposed rule replicates the ACA strategy of blunting incentives' potential impact by imposing a ceiling, but the regulatory structure it adopts focuses on the disability-related concerns at the heart of the ADA rather than the insurance-related concerns at the heart of the ACA. The differences between the ACA and ADA rules mean that ACA-compliant incentives will sometimes, but not always, run afoul of the ADA. Whether the EEOC's reply is the correct one is open to debate. Any assessment of the proposed rule will need to confront the question of how best to reconcile sometimes-competing policy objectives.

IV. THE WELLNESS INCENTIVE CEILING: CONFRONTING DIVERGENT POLICY OBJECTIVES

The comments submitted in response to the proposed regulation highlight the challenges the EEOC will face in finalizing the regulations. A common theme in comments submitted by advocacy organizations for individuals with disabilities is that the EEOC has gone too far in permitting incentives and not far enough in requiring protections. Several organizations highlighted the continuing vitality of the ADA, emphasizing that its antidiscrimination provisions confer protections that are distinct from those of the ACA.¹³⁷ Many

137. See, e.g., The Judge David L. Bazelon Center for Mental Health Law, Comment Letter on Proposed Rule, Amendments to Regulations Under the Americans With Disabilities Act 2-11 (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0311&attachmentNumber=1&disposition=attachment&contentType=pdf>

commenters suggested that incentives approaching the 30% limit specified in the regulation would make wellness program participation involuntary, and several argued that the ADA should not accommodate incentives based on examinations or disability-related inquiries at all,¹³⁸ pointing to GINA's treatment of genetics-related inquiries as a model.¹³⁹

By contrast, organizations associated with large employers and entities providing wellness services applauded the decision to permit financial incentives, and often argued that the EEOC should have gone further in accommodating incentive arrangements deemed acceptable under the ACA.¹⁴⁰ They argued, for example, that only participatory programs involving disability-related inquiries or medical examinations should be counted toward the 30% ceiling, or that participation-based wellness programs should not count at all.¹⁴¹

[hereinafter Bazelon Center Letter]; American Cancer Society Cancer Action Network, Comment on Proposed Rule, Amendments to Regulations under the Americans with Disabilities Act (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0256&attachmentNumber=1&disposition=attachment&contentType=pdf> [hereinafter Cancer Action Network Letter]; National Council on Disability, Comment Letter on Proposed Amendments to Regulations Under the Americans with Disabilities Act (June 4, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0155&disposition=attachment&contentType=pdf>.

138. American Association of People with Disabilities, Comment on Proposed Rule, Amendments to Regulations Under Americans With Disabilities Act (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0189&attachmentNumber=1&disposition=attachment&contentType=pdf>; Bazelon Center Letter, *supra* note 137, at 3–6, 15; Cancer Action Network Letter, *supra* note 137, at 3–4; *see also* Families USA, Comment on Amendments to Regulations under the Americans with Disabilities Act NPRM 1–3 (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0268&attachmentNumber=1&disposition=attachment&contentType=pdf>.

139. Bazelon Center Letter, *supra* note 137, at 15; Families USA, *supra* note 138, at 3.

140. *See, e.g.*, National Business Group on Health, Comment on Amendments to Regulations Under the Americans with Disabilities Act 1 (June 19, 2015), <http://www.regulations.gov/0266&attachmentNumber=1&disposition=attachment&contentType=pdf> (“[T]he EEOC can go further in aligning its rules, and, frankly, eliminating contradictions with these other laws that still remain in the proposed rule as it finalizes this rule in the months ahead.”) [hereinafter NBGH letter]; Business Roundtable, Comment on Amendments to Regulations Under the Americans with Disabilities Act 2 (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0162&attachmentNumber=1&disposition=attachment&contentType=pdf> [hereinafter Business Roundtable Letter]; Annette Guarisco Fildes, The ERISA Industry Committee, Comment on Amendments to Regulations Under American with Disabilities Act 4–6 (June 18, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0128&attachmentNumber=1&disposition=attachment&contentType=pdf> [hereinafter ERIC Letter].

141. NBGH Letter, *supra* note 140, at 1 (“Incentives for participation-only wellness programs should not be limited and they should not count toward the incentive cap for the purposes of ADA compliance.”); Business Roundtable Letter, *supra* note 140, at 3 (urging

They suggested that when family members are eligible for incentives, regulators should follow the ACA approach: the ceiling should be applied to the cost of family coverage, rather than the cost of employee-only coverage.¹⁴² They also lamented the rule's potential implications for tobacco cessation incentives offered under the ACA's 50% cap.¹⁴³

In short, some commenters argued for closer alignment between the ADA and ACA exceptions, while others rejected the use of the ACA as a guidepost in interpreting the ADA's wellness exception. The commenters' differing views reflect differing levels of enthusiasm for incentive-based wellness programs, but that is only one of many factors that should be considered in defining the scope of the ADA's exception. Ultimately, the degree of alignment between the ADA and ACA incentive limits should turn on the extent to which the current ACA limits are consistent with the goals underlying the ADA's inquiry and examination prohibition, as modified by the ADA's health program exception. Using an analysis of the ACA's wellness program provisions as a starting point, the remainder of Part IV considers the extent to which the structural features of the proposed incentive limit under the ADA help to advance these goals.

A. Voluntariness, Undue Inducement, and Coercion in the Context of Information Revelation

Policymakers' goals in establishing the disability-related inquiry prohibition and its exception can be inferred from both the text of the relevant provisions and the circumstances surrounding their creation. The ADA sought to prevent discrimination against individuals with disabilities in employment through a general prohibition on disability-

clarification that the 30% limit "only applies to participatory programs that include medical testing"); John R. Hickman, Alston & Bird, Comment on Proposed Regulations Regarding Amendments to Regulations Under the Americans with Disabilities Act 4 (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0260&attachmentNumber=1&disposition=attachment&contentType=pdf> (proposing that "rewards that could be obtained without a disability related inquiry (or medical exam) would not count toward the 30% threshold.").

142. NBGH Letter, *supra* note 140, at 1; Business Roundtable Letter, *supra* note 140, at 2; ERIC Letter, *supra* note 140, at 4–6.

143. NBGH Letter, *supra* note 140, at 2; Business Roundtable Letter, *supra* note 140, at 2–3; Cleveland Clinic, Comment on Proposed Rule, Amendments to Regulations Under the Americans with Disabilities Act 4–5 (June 15, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0204&attachmentNumber=1&disposition=attachment&contentType=pdf>.

based discrimination “in regard to . . . hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions and privileges of employment,”¹⁴⁴ a prohibition that extends to “medical examinations and inquiries,”¹⁴⁵ whether undertaken before or during employment, subject to some exceptions.¹⁴⁶ Pre-offer prohibitions on inquiries were put in place “to assure that misconceptions do not bias the employment selection process,”¹⁴⁷ so that employers’ focus would remain squarely on the applicant’s abilities to perform the job. Similarly, after employment begins, “the actual performance on the job is, of course, the best measure of the employee’s ability to do the job,”¹⁴⁸ so the circumstances in which collection of disability-related information would be appropriate are limited. Consistent with this view, the ADA states that covered entities “shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability” unless the inquiry or examination is “job-related and consistent with business necessity.”¹⁴⁹ According to a scholar involved in the drafting of the ADA, advocates for the inquiry-examination limit sought to “prohibit employers from inquiring into particular disabilities, such as HIV infection, which pose a social stigma simply by identification, but have no relevance to the person’s ability to perform the job.”¹⁵⁰ The provision’s legislative history articulated the concern that if an examination is not job related, it “simply serves to stigmatize the person with a disability.”¹⁵¹

However, as previously described in Part III, the drafters of the ADA acknowledged that non-job-related inquiries and examinations do have at least one permissible purpose: facilitating the operation of voluntary employer-sponsored wellness programs. The House Report explains that “[a]s 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

144. 42 U.S.C. § 12112(a) (2013).

145. *Id.* § 12112(d)(1).

146. *Id.* § 12112(d)(2)–(4).

147. H.R. REP. NO. 101-485, pt. 2, at 72–73 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 355–56.

148. *Id.*

149. *Id.* § 12112(d)(4)(A).

150. Chai R. Feldblum, *Medical Examination and Inquiries Under the Americans with Disabilities Act: A View from the Inside*, 64 TEMP. L. REV. 521, 536 (1991).

151. H.R. REP. NO. 101-485, at 75.

occupational advancement, these activities would fall within the purview of accepted activities.”¹⁵² The ADA thus provides an exception to the general prohibition on disability-related inquiries and examinations for “voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site.”¹⁵³

The EEOC’s task in the ADA rulemaking, then, is to determine the circumstances under which incentives would render medical examinations or medical histories involuntary. As detailed in Part III, the EEOC previously offered views on this question in the form of enforcement guidance. In its 2000 guidance, the EEOC explained the ADA’s exception by linking the term “voluntary” to the concept of the “wellness program,” rather than to inquiries or examinations. This approach departs from the ADA’s statutory text but is consistent with the House Report’s use of the term “voluntary”; the EEOC stated that employees may be asked questions and given examinations “pursuant to such voluntary wellness programs.”¹⁵⁴ It then stated that a “wellness program is ‘voluntary’ as long as an employer neither requires participation nor penalizes employees who do not participate.”¹⁵⁵ In the formal rulemaking underway now, the EEOC is revisiting the question of how best to define voluntariness within the context of wellness programs.

The ADA does not define “voluntary,” and the House Report does not dwell on the concept. What purpose does the ADA’s voluntariness condition serve? At the very least, the voluntariness condition should preclude employers from circumventing the prohibition on disability-related inquiries and medical examinations by mandating participation in an inquiry-based wellness program as a condition of employment. Employers cannot require participation in an inquiry-based wellness program; they can only make it available as an option. The ADA contemplates that employees will weigh wellness programs’ potential benefits and costs, including potential costs associated with stigma and discrimination, and make their own decisions about whether to reveal disability-related information pursuant to a wellness program. Some employees do indeed choose to reveal this information, while others do not. One survey found that

152. *Id.*

153. *Id.* § 12112(d)(4)(B).

154. *Enforcement Guidance*, *supra* note 97.

155. *Id.*

while the most commonly cited reasons for declining participation in wellness programs were time constraints and a belief that the program was not needed to make changes,¹⁵⁶ about 13% cited as a major reason a worry “that [their] employer will know [their] personal health information,” and another 20% cited such worries as a minor reason.¹⁵⁷

If the trouble with mandatory participation is that it leads individuals to reveal information that they would not otherwise reveal, should incentives that encourage information revelation also be deemed to render wellness program participation involuntary? After all, an employer denied the ability to mandate participation might turn to incentives to attempt to achieve the same result.

Mandates and incentives operate through different mechanisms, and this may matter in thinking about the relationship between incentives and voluntariness. Mandates strip employees of their option to decline to participate in wellness programs, foreclosing the process of weighing intrinsic costs and benefits of participation. By contrast, incentives preserve both the option and the decision-making process, but inject considerations that go beyond the intrinsic program costs and benefits into the decision making. If incentives are tied directly to the provision of information, or to any program, activity, or outcome for which information provision is required, rational employees will take these incentives into account when deciding whether to reveal information. From the employee’s perspective, incentives are real costs or benefits on par with intrinsic program costs and benefits, and their availability may sometimes alter the employee’s decision. Indeed, the very purpose of incentives is to do so; employers offer HRA incentives to encourage participation.

Observers may worry that incentives generate too many bad decisions, decisions to participate in programs for which intrinsic costs to the employee outweigh intrinsic benefits. It is certainly possible that incentives will yield this result. For example, while the ADA requires protections for information collected, perhaps the risk of a breach of confidentiality is especially high or its consequences especially serious.¹⁵⁸ Or, perhaps the wellness program is poorly

156. Paul Fronstin, *Findings from the 2013 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey*, EMP. BENEFIT RES. INST., Dec. 2013, at 12.

157. *Id.* at 17.

158. 42 U.S.C. §12112(d)(4)(c); *id.* § 12112(d)(3)(B)–(C). EEOC enforcement guidance indicates that medical records in wellness programs must be “kept confidential and separate from personnel records.” *Enforcement Guidance*, *supra* note 97.

designed, and its benefits are minimal. In either case, if an incentive is sufficiently large, an employee might rationally choose to engage in these programs despite their shortcomings.

The high-risk or low-benefit scenarios are not the only ones in which incentives might make a difference. Another possibility is that risks are low and benefits are high, but employees are reluctant to invest the time and attention required to get started with the program. In such cases, a reward might compensate for the costs involved, altering employees' cost-benefit analysis and encouraging more of them to participate in HRAs. Or perhaps risks are sufficiently low and benefits sufficiently high that the intrinsic benefits of HRA-based wellness programs actually outweigh the risks and cost involved, but employees nevertheless initially decline to participate because of faulty evaluations of the program's likely impact.¹⁵⁹ They might overestimate the informational risks involved, underestimate the difficulties of addressing health problems on their own, or fail to understand their own health risks or the nature of the services offered. In such cases, incentives can result in good decisions that might not otherwise be made.¹⁶⁰

The fact that incentives boost participation levels tells us little about the merits of the underlying decision to participate; it reveals only that some employees' assessment of the situation has changed. Ultimately, though, the question of voluntariness cannot be answered by examining the underlying merits of wellness programs, or even by considering whether employees have properly evaluated risks, costs, benefits, and incentives in the course of making their decisions. The fact that people might occasionally make mistakes in assessing a situation does not itself render the resulting decision involuntary.

Some might argue that the very presence of added incentives

159. For further discussion on this point, see Madison, Volpp & Halpern, *supra* note 59, at 452–53.

160. These scenarios do not capture all of the possibilities one might want to consider in a comprehensive evaluation of wellness incentives' effects. For example, incentives might increase the likelihood of faulty decisionmaking, a possibility discussed below in the evaluation of undue inducement. They might focus attention on the short term, at the expense of the long term. They might generate effects such as increased productivity that are not immediately transparent to employees, and so are not captured in their decisionmaking. They might also generate externalities that individual employees ignore, such as creating an unwelcome environment for individuals who would prefer that health issues remain outside of the workplace. This passage does not offer a comprehensive analysis of wellness incentives. Instead, it points out that any assessment of incentives' effects will require a careful evaluation of the circumstances surrounding individuals' decisions.

undermines voluntariness. In the comment it submitted to the EEOC, the Bazelon Center noted the EEOC's earlier position that voluntariness precluded penalties and pointed to dictionary definitions that emphasized the absence of "valuable consideration" as an element of voluntariness.¹⁶¹ The weakness in a dictionary-based argument is that dictionaries often offer multiple definitions. While the Merriam-Webster Dictionary defines "voluntary" to include "acting or done of one's own free will without valuable consideration or legal obligation," another definition is "proceeding from the will or from one's own choice or consent."¹⁶² Consider an individual who chooses to work for an employer that offers a good salary, but would not volunteer to work for the employer for free. Does the salary make the individual's decision to work for the employer involuntary? Would the individual's unwillingness to volunteer suffice to establish that the individual's decision was involuntary? It seems reasonable to conclude that incentives can sometimes be compatible with voluntariness.

It also seems reasonable to conclude that incentives could sometimes make a decision to participate involuntary. If an employer offers all employees an "opportunity" to complete an HRA, but then imposes a penalty equivalent to an individual's entire salary for those who choose not to complete it, the situation is not much different from an employer that requires responses to disability-related inquiries as a condition of employment.¹⁶³ A one dollar reward, by contrast, seems unlikely to render a decision involuntary, even if it induces someone to participate who would not have otherwise. But then where should the line be drawn?

Ethicists have confronted similar line-drawing questions in the context of human subjects research. In this context, the concern is the possibility that incentives might have an ethically problematic influence over individuals' decisions to participate in health research that imposes risks. While the situation is not fully parallel, these scholars' insights could suggest ways of thinking about HRA participation that imposes risks. In evaluating participation incentives, scholars consider the possibility of "undue inducement," often focusing on the idea that rewards might lead to irrational

161. Bazelon Center Letter, *supra* note 137, at 4.

162. *Voluntary*, MERRIAM-WEBSTER DICTIONARY & THESAURUS, <http://www.merriam-webster.com/dictionary/voluntary> (last visited Aug. 8, 2015).

163. See Madison, Volpp & Halpern, *supra* note 59, at 458.

decision making or interfere with risk perception.¹⁶⁴ In other words, in thinking about the ethical implications of a research participant's decision to take on risk, scholars consider the influence of incentives on the decision-making process. They may also take into account the results of decision making: one leading ethicist argues that undue inducement further requires that the bad judgment associated with the inducement lead to "ethically, legally, or prudentially undesirable activities" with a "risk of a serious adverse effect."¹⁶⁵

Would a \$500 reward for the completion of an HRA have the potential to undermine employee decision making, or result in undesirable activities? While HRAs might sometimes carry risks of stigma, it seems unlikely that \$500 offered through an employer-sponsored wellness program would blind employees to these risks; \$500 might outweigh the risks, but it would probably not lead employees to ignore them. This conjecture finds some support in the human subjects research context; studies have failed to find a link between incentives and deficiencies in risk perception.¹⁶⁶ Furthermore, disclosing information would not ordinarily be considered an inherently undesirable activity, apart from the privacy and stigma risks that might be associated with it. Indeed, the creation of the wellness program exception implies the opposite: Congress believes that, on balance, disclosure may be desirable. There are risks of adverse effects, and their nature and magnitude will depend on many factors, including the content of the information disclosed. These risks are mitigated by the information protections that Congress has mandated, however, and ultimately Congress did not see them as so severe as to fully ban examinations and inquiries.¹⁶⁷ Congress's willingness to permit these risks is also reflected in provisions that allow employers to mandate post-offer, pre-employment medical examinations under certain circumstances.¹⁶⁸ For these reasons, it seems inappropriate to characterize wellness incentives as undue

164. *Id.* at 461.

165. Ezekiel J. Emanuel, *Ending Concerns About Undue Inducement*, 32 J.L. MED. & ETHICS 100, 101 (2004).

166. See Madison, Volpp & Halpern, *supra* note 59, at 461 (describing two studies, including one that found "that higher payments might heighten awareness of risk, rather than blind individuals to its presence").

167. See *supra* note 158 and accompanying text.

168. 42 U.S.C. § 12112(d)(3) (2013); cf. Mark A. Rothstein, *Genetic Discrimination in Employment and the Americans with Disabilities Act*, 39 HOUS. L. REV. 23, 53–61 (1992) (noting the risks this provision imposes and critiquing the EEOC's interpretation of it).

inducements.

When incentives function as penalties, they might be viewed as undermining voluntariness by being “coercive.” Scholarly definitions of coercion vary, but they generally reflect the principle that incentives can coerce only if they worsen an individual’s situation or violate an individual’s rights.¹⁶⁹ The notion of individual rights is not especially helpful in this context, since the nature of these rights remains to be defined; the EEOC must settle upon a definition of voluntariness before it can determine employers’ obligations toward their employees. The more easily supported claim is that wellness incentives might worsen employees’ situations. Some scholars have said that to be coercive, penalties must threaten “severe” harm or leave an individual with “no reasonable alternative.”¹⁷⁰

It is difficult to attach specific numbers to these very general characterizations. Could the failure to obtain a \$500 reward for completing an HRA appropriately be described as a “severe” harm (if it is to be characterized as a harm at all), or one that leaves someone with “no reasonable alternative”? What about a \$500 premium surcharge for tobacco users directed at someone who refuses to take a cotinine test? If these harms do seem severe with respect to individual employees, do we need to consider whether incentive programs in general are successful at reducing employee health care costs or boosting overall productivity, and, if so, whether gains are shared with workers in the form of lower premiums or higher pay? In that case, indirect benefits to the employee may offset some of the direct harms experienced through refusing to participate.¹⁷¹ Determining a baseline against which to measure an employee’s harm is conceptually difficult in a setting in which the employer plays a role in defining all of the terms and conditions of employment, including the terms of a benefit plan.¹⁷²

B. An Incentive Ceiling Based on the Cost of Coverage?

Regardless of the theoretical complexities, the idea that incentives can be so large as to be problematic is clearly reflected in regulators’ decisions. It may be difficult to determine the appropriate lines to draw, but regulators draw them. Under the ACA, regulators

169. See Madison, Volpp & Halpern, *supra* note 59, at 459–60.

170. *Id.*

171. See *id.* for a numerical example.

172. See *id.*

seeking to avoid a “reward or penalty . . . so large as to have the effect of denying coverage or creating too heavy a financial penalty” chose to set a limit for health-contingent incentives at 20% of the cost of coverage, a number that legislators later adjusted upward to 30%, or 50% for certain programs targeting tobacco use.¹⁷³ From the perspective of employees, incentives that reach this ceiling are likely to feel very large. Incentives at the 30% ceiling could easily exceed the total amount that employees contribute toward their own insurance. A 2014 survey conducted by the Kaiser Family Foundation found that employees paid, on average, about 18% of the cost of employee coverage, and about 29% of the cost of family coverage.¹⁷⁴ The high average costs of coverage mean that 30% ceilings are high in terms of the total number of dollars involved—as of 2014, about \$1,800 for an average individual plan, and \$5,100 for a family plan.¹⁷⁵ Note that the average household income for those under 65 is around \$58,400.¹⁷⁶ Nevertheless, by setting a ceiling at 30% of the cost of coverage, Congress indicated that this amount is not “too heavy a financial penalty.”¹⁷⁷

What does this mean for the determination of voluntariness under the ADA? One argument might be that if 30% of the cost of coverage is not too heavy a penalty to tie to health-status related factors when the affordability of insurance is in question, then it should also not be so heavy a penalty that it renders a disability-related inquiry or medical examination involuntary. Under this view, regulators’ efforts under the ACA are essentially efforts to prevent coercion, and a ceiling that prevents coercion in the ACA context could also prevent coercion in the ADA context.¹⁷⁸

Things are not quite so straightforward. Although Congress set the 30% limit for health-contingent incentives, regulators later permitted penalties of up to 50% for programs targeting tobacco

173. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,018 (Dec. 13, 2006) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 29 C.F.R. pt. 146). See discussion *supra* Part II.

174. See CLAXTON ET AL., *supra* note 23, at 2.

175. See *id.*

176. CARMEN DENAVAS-WALT & BERNADETTE D. PROCTOR, U.S. CENSUS BUREAU, INCOME AND POVERTY IN THE UNITED STATES: 2013, at 14 (2013), available at <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf>.

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

178. See Blue, *supra* note 2, at 382–83 (describing this argument).

use.¹⁷⁹ If the assumption is that regulators would not allow for coercive health incentives, then it makes as much sense to use the 50% ceiling as to use the 30% ceiling. While some might view the 50% limit as reasonable, others would argue that the higher ceiling reflects tobacco-related policy objectives, and not just a concern about the coercive impact of sizeable incentives in a general sense. But the same argument could be made with respect to the ACA's 30% ceiling; this ceiling, too, is the product of multiple policy objectives, including those related to incentive programs and those related to insurance affordability. To transfer the thirty-percent-of-the-cost-of-coverage ceiling to the ADA setting, an argument must be made that coercion concerns in the inquiry-examination setting should be treated the same way as coercion concerns in the insurance affordability setting.

One reason for thinking twice about importing the 30% ceiling is that it is not clear why the ADA ceiling should be tied to the cost of coverage. In the ACA setting, if there is a positive relationship between total coverage costs and affordability for enrollees (e.g., if employers with higher-paid employees offer more expensive health coverage), then setting the ceiling as a fraction of coverage costs would allow for larger incentives for the enrollees most likely to be able to afford them, but constrain incentives for those with low-cost coverage. Tying the limit to the cost of coverage also means that employers with the most expensive insurance coverage have the most room to implement incentives to improve employee health and reduce coverage costs, which has some intuitive appeal, even if it has more to do with the employer's situation than the financial pressure an individual enrollee feels.

At the same time, the cost-of-coverage ceiling is not necessarily a perfect fit with either the ACA or the ADA policy objectives. According to the Kaiser Family Foundation annual survey, about a quarter of covered workers have annual premiums of less than \$5,000, while just under a quarter have annual premiums of more than \$7,000, which with a 30% ceiling would mean a difference in ceiling levels of over \$600. Individuals with low take-home pay and rich insurance packages may end up facing daunting levels of incentives.

The EEOC floated the possibility of a different type of incentive ceiling in its notice of proposed rulemaking. It noted that in 2015, health insurance would be deemed affordable under the ACA "if the

179. See 45 C.F.R. § 146.121(f)(5) (2014).

portion an employee would have to pay for employee-only coverage would not exceed” 9.56% of household income.¹⁸⁰ It then asks whether it should limit wellness program participation incentives to a level that would not render a plan unaffordable as determined by the ACA rules.¹⁸¹ A household income-based formula would probably do a better job of tailoring ceilings to enrollees’ situations; it could reduce the level of pressure felt by low-income individuals covered by employers that offer rich benefit packages. However, there are many drawbacks to this approach. In addition to creating administrative complications, if an income-specific ceiling is binding, then an employer must either limit incentives to a level suitable for the lowest-income employee, or permit otherwise similarly situated employees to be treated differently, depending on levels of household income. Families USA, a consumer-oriented commenter, noted that it had “some reservations about establishing means-tested standards for applying disability rights that should be equally secured for all workers.”¹⁸² Other commenters noted that a ceiling based specifically on the ACA’s concept of affordability would allow penalties that are much too high.¹⁸³

C. *The Nature of Incentives*

If the goal of the ADA proposed rule is to ensure voluntariness of the provision of disability-related information, then the ceiling’s height is only one part of the formula that must be examined. The nature of incentives compared to the ceiling also matters. The HIPAA–ACA ceiling is applied to health-contingent incentives, which is consistent with these statutes’ underlying goal of preventing discrimination based on health factors.¹⁸⁴ By the same reasoning the ADA’s proposed ceiling ought to apply to incentives that are contingent on disability-related inquiries or medical examinations,

180. ADA Proposed Rule, *supra* note 88, at 21,664.

181. *Id.* at 21,664 (describing 26 U.S.C. § 36B(c)(2)(C) as implemented by Treas. Reg. § 54.4980H–5(e)). This threshold is relevant to the determination of whether employers offer affordable coverage to their employees, which in turn is relevant to the determination of employer penalties under the ACA. See *Employer Responsibility Under the Affordable Care Act*, HENRY J. KAISER FAM. FOUND., <http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/> (last updated Dec. 17, 2014).

182. See Families USA, *supra* note 138, at 3.

183. Bazelon Center Letter, *supra* note 137, at 15. See also Families USA, *supra* note 138, at 3.

184. 45 C.F.R. § 146.121(f)(3)(ii), (4)(ii).

thus limiting the pressure on individuals to reveal disability-related information. The ceiling should generally apply to incentives tied to HRA completion as well as to any participation-, activity-, or outcome-based incentives available only to individuals who answer disability-related questions or undergo medical examinations.

The proposed rule appears to deviate from this approach in a few ways. For example, it might be read to include some incentives that are not contingent on inquiries or examinations. Consider the language of the proposed regulation:

The use of incentives . . . together with the reward for any other wellness program that is offered as part of a group health plan . . . will not render the program involuntary if the maximum allowable incentive available under the program (whether the program is a participatory program or a health-contingent program . . .) does not exceed 30 percent of the total cost of employee-only coverage.¹⁸⁵

The question is whether this language sweeps within it incentives that do not depend on disability-related inquiries or medical examinations, such as a \$50 reward for attending a nutrition-education course. There is nothing in the language of the provision that would exclude such a program from the calculation. Later in the notice of proposed rulemaking, however, the EEOC refers to “the maximum allowable incentive for a participatory program that involves asking disability-related questions or conducting medical examinations.”¹⁸⁶ It also acknowledges that “[n]ot all wellness programs require disability-related inquiries or medical examinations in order to earn an incentive,”¹⁸⁷ and that these “programs that are not subject to the ADA incentive rules discussed here.”¹⁸⁸ But it is not clear whether the EEOC means simply that if there are no inquiries or examinations, then no further analysis of incentive magnitudes is required, or if it means that in circumstances when analysis is clearly required, only incentives that are contingent on inquiries or examinations are subject to the ceiling. For example, if an employer’s only incentive is a \$50 reward for attending a nutrition

185. ADA Proposed Rule, *supra* note 88, at 21,667 (proposed 29 C.F.R. § 1630.14(d)(3)).

186. *Id.*

187. *Id.*

188. *Id.*

class, then it will not be subject to the ADA incentive rules, since no inquiry or examination is involved. But if the program also ties \$500 to an HRA, should the \$50 be added to the \$500 for purposes of determining whether program incentives render the program involuntary?

Several organizations have submitted comments suggesting that this rule applies too broadly to participatory programs, or that its application to participatory programs is unclear.¹⁸⁹ One way to clarify the rule would be to require that the ceiling be applied only to wellness incentives that are contingent on responding to disability-related inquiries or undergoing medical examinations. This approach would include incentives for HRAs with disability-related questions but exclude incentives for nutrition classes as well as health-contingent incentives that do not involve disability-related inquiries or medical examinations. For example, incentives awarded to individuals for not smoking, as determined by a questionnaire, could be excluded.¹⁹⁰

D. Incentives for Family Members

The proposed rule might also be considered overinclusive in another way: Its incentive calculations appear to include rewards and penalties directed at employees' family members, without making an associated adjustment to the incentive ceiling. The only ceiling the rule describes is based on the cost of employee-only coverage.¹⁹¹ But in describing the incentives to be compared to this ceiling, it provides no specific exclusion for incentives directed at employees' dependents who are health plan beneficiaries.¹⁹² As a result, the provision seems to suggest that these family incentives should be aggregated and attributed to the employee. If this sum is limited by a ceiling that is based on the costs of employee-only coverage, then employers that are constrained by the ceiling will either need to limit the incentives they offer to family members, or reduce the magnitude of incentives offered to the employee so as to accommodate the incentives offered to family members.

189. See NBGH Letter, *supra* note 140, at 1; Business Roundtable Letter, *supra* note 140, at 3; Hickman, *supra* note 141, at 4.

190. This approach appears to be consistent with the EEOC's view of how the ADA should be applied to smoking cessation incentives. See ADA Proposed Rule, *supra* note 88, at 21,668–69.

191. *Id.* at 21,667 (proposed 29 C.F.R. § 1630.14(d)(3)).

192. *Id.*

There are at least two alternatives to including family incentives in the aggregate, but not in the ceiling. The first alternative is to exclude family incentives from both the aggregate and the ceiling. In other words, the employee-only ceiling could remain in place, but the proposed rule could be clarified or revised to ensure that incentives directed at individuals other than the employee are disregarded in a voluntariness analysis. A second alternative is to include family incentives in both the aggregate and the ceiling. This is the approach the ACA takes in defining the wellness program exception to health plan nondiscrimination rules: the ACA ceiling applies to the “cost of coverage in which an employee or individual and any dependents are enrolled” when “any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program.”¹⁹³ A number of commenters representing employers have argued that the ADA should similarly use the cost of family coverage as the baseline when the calculation includes incentives offered to family members.¹⁹⁴

In the ACA context, extending wellness programs’ incentive ceiling to dependents is consistent with the structure of the nondiscrimination rules as well as the wellness exception. The health plan antidiscrimination provisions expressly apply both to enrolled individuals and their enrolled dependents.¹⁹⁵ If the primary goal of the wellness program regulations is to promote health for all enrolled individuals while preserving the affordability of coverage for everyone, then it makes sense to include family incentives both when calculating total rewards and penalties and when determining the ceiling.

This rule may substantially increase total health coverage costs borne by employees whose family members do not obtain rewards, and the aggregate increases such employees face will be higher than the increases experienced by employees without dependents. Note though that the employee’s greater exposure to incentive-related costs results from the employee’s more extensive use of plan benefits. The family is ultimately shielded in the same way an individual employee is shielded: The family coverage cost-based ceiling constrains the size of any potential increase at a level tied to the aggregate costs of

193. 42 U.S.C. § 300gg-4(j)(3)(A) (2013).

194. See NBGH Letter, *supra* note 140, at 1; Business Roundtable Letter, *supra* note 140, at 2; ERIC Letter, *supra* note 140, at 4–6.

195. I.R.C. § 9802(b) (2014).

providing benefits to family members, just as the individual coverage cost-based ceiling constrains the magnitude based on the costs of providing benefits to individuals.

The decision to include families in the ACA incentive calculations is natural, given the purpose and structure of the ACA. The ADA, however, is structured differently: its prohibition on disability-related inquiries and medical examinations contains specific references to employees but not to family members.¹⁹⁶ For this reason, one might argue that the question of voluntariness should depend on the incentives facing the employee who is in the midst of making a decision about whether to reveal disability-related information to a wellness program. The employee should take into account the incentives associated with his or her own decision, not incentives tied to an independent decision made by his or her spouse. If an employee can decline to participate while the employee's spouse completes an HRA and receives the associated reward, then it would seem inappropriate to conclude that the spouse's incentives would have the potential to undermine the voluntariness of the employee's decision.

From this perspective, if the proposed rule requires aggregating family incentives along with individual incentives for comparison to an employee-only ceiling, it seems overinclusive. If family incentives are included in the calculation, then it will provide a misleading picture of wellness incentives' potential influence over the employee's decision to reveal information. It seems more appropriate to exclude family members from the analysis entirely, so that employee-only incentives are compared to the costs of employee-only coverage.

On the other hand, the origin of the limitation on inquiries and examinations is the ADA's prohibition against discrimination, and the ADA defines discrimination to include denial of benefits based on the disabilities of individuals with whom the covered individual is known to have a relationship.¹⁹⁷ In other words, the ADA contemplates the possibility that employment discrimination could occur based on the

196. 42 U.S.C. § 12112(d)(4) (2013). The House Report also focuses on the implications of inquiries and examinations for employees, rather than family members. See H.R. REP. NO. 101-485, at 75.

197. See 42 U.S.C. § 12112(d)(1) ("The prohibition against discrimination as referred to in subsection (a) of this section shall include medical examination and inquiries."); *Id.* § 12112(b)(4).

disabilities of others.¹⁹⁸ By extension, then, inquiries about the disabilities of others could pose a risk for discrimination against an employee, and there is reason to consider the incentives offered for such inquiries.¹⁹⁹ The ACA's approach offers a mechanism for doing this; a calculation based on aggregate incentives and family coverage costs approximates the analysis that would be applied in the case of an individual employee. For example, if the cost of covering a family is \$12,000 and employees and their spouses are each awarded \$1,000 for HRA completion, the calculation would be equivalent to the situation in which the cost of individual coverage is \$6,000 and the employee is awarded \$1,000 for HRA completion.

Either of these two approaches—including family incentives in the pool and using a family coverage-based ceiling or omitting family incentives from consideration entirely—would give employers more room to offer incentives to employees' dependents through the health plan. Some might be concerned that both options extend employers' reach even further beyond the workplace than do employee-only incentives, but these options permit employers to try to promote wellness among family members. Providing incentives to family members might also reinforce employers' efforts to promote health among employees. Several commenters suggested that involving family members increases employees' engagement in wellness programs.²⁰⁰

E. Incentives Outside of Health Plans

Parts IV.C and D suggest two ways in which the proposed rule could be viewed as overinclusive: If the employee-only coverage cost

198. See Mark A. Rothstein, *Innovations of the Americans with Disabilities Act: Confronting Disability Discrimination in Employment*, 313 JAMA 2221, 2221 (2015) (discussing associational discrimination in the context of the ADA).

199. GINA is another context in which regulators have indicated concern about the implications for the employee of the collection of family health information. Indeed, in the Honeywell suit, the EEOC alleged that “[m]edical information related to manifested conditions of spouses is family medical history – or genetic information – under GINA,” and that “Honeywell is offering an inducement to its employees to acquire genetic information in violation of GINA.” EEOC’s Petition, *supra* note 111, ¶¶ 37–38. The EEOC has said that it will address GINA’s implications in future rulemaking. ADA Proposed Rule, *supra* note 88, at 21,660 n.3.

200. See American College of Occupational and Environmental Medicine, Comment on Proposed Rule, Amendments to Regulations Under American with Disabilities Act 2 (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0315&attachmentNumber=1&disposition=attachment&contentType=pdf>; NBGH Letter, *supra* note 140, at 4–5.

ceiling applies to incentives not contingent on disability-related inquires or medical examinations, or if it includes incentives offered to family members, then arguably the rule encompasses too broad a range of incentives. There may very well be good policy reasons to structure the rule in these ways, but the rule would not align well with what seem to be the goals of the inquiry-examination prohibition and its exception for voluntary wellness programs. In another way, however, the proposed rule's incentive ceiling could also be viewed as underinclusive: It applies only to incentives offered through health plans, not to incentives offered outside of health plans.²⁰¹

In the notice of proposed rulemaking, the EEOC asks whether employers offer incentives outside of health plans, and if so, whether the scope of the ADA regulations should be expanded to limit these incentives.²⁰² As described in Part II, surveys from both the Kaiser Family Foundation and the RAND Corporation found that it is common for employers to offer incentives outside of health plans.²⁰³ Commenters offered several examples of wellness initiatives that are not based on health plans, including walking programs, gym memberships, weight-loss challenges, programs that reward eating vegetables and drinking water, and wellness-themed raffles.²⁰⁴ If any incentives offered in conjunction with these activities involve disability-related inquiries or medical examinations, then it would seem appropriate to subject them to the ceiling, particularly if regulators have concerns about the possibility of undue inducement. The HIPAA-ACA wellness program regulations target incentives in health plans because they are defining an exception to a limitation on discrimination in health plans. The ADA's limitation on disability-related inquiries is not restricted to health plans, and so it is reasonable to conclude that its voluntary wellness program exception

201. The proposed provision refers to “[t]he use of incentives . . . in an employee wellness program . . . together with the reward for any other wellness program that is offered as part of a group health plan.” ADA Proposed Rule, *supra* note 88, at 21,667 (proposing 29 C.F.R. § 1630.14(d)(3)).

202. *Id.* at 21,664.

203. *See supra* notes 75–77 and accompanying text.

204. NBGH Letter, *supra* note 140, at 6–7 (exercise program, weight-loss challenge, raffle); ERIC Letter, *supra* note 140, at 13 (gym membership); Michael G. Paton & Patricia L. Ogden, Barnes & Thornburg LLP, Comment on Proposed Rule, Amendments to Regulations Under the Americans with Disabilities Act (June 18, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-00060324&disposition=attachment&contentType=pdf> (pedometers, weight-loss competitions, walking clubs, lifestyle-change program rewarding healthy activities such as eating vegetables and drinking water).

should not be either. If regulators are concerned that high levels of incentives might undermine the voluntariness of wellness programs, there seems to be little reason to distinguish between dollars offered inside health plans and dollars offered outside health plans.

This raises the question of why the EEOC has chosen to focus on health plans in the first place. One possible answer is that the EEOC was under pressure to respond to employers who protested the possibility that ACA-compliant programs might run afoul of the ADA. Because the relevant ACA provisions targeted wellness programs that might otherwise violate provisions prohibiting discrimination in health plans, the EEOC's attention was drawn specifically to plan-based incentives. The EEOC's silence on incentives outside of health plans leaves unanswered questions about the extent to which such incentives could render a wellness program involuntary.

Some might argue that such incentives should be disallowed in their entirety, while others might argue that they should be permitted without restriction. Indeed, such suggestions are among those made by commenters.²⁰⁵ It seems inappropriate to prohibit incentives outside of health plans, given the EEOC's apparent willingness to permit incentives inside of health plans. In general, there is no reason to believe that these incentives pose a greater risk to voluntariness than health plan-based incentives. Critics of wellness incentives may be concerned about the potential impacts of incentives not constrained by the HIPAA-ACA regulations, which apply only to health plan-based incentives. But it is not clear that these concerns relate to voluntariness, and if they do, they could be addressed through additional regulation.

It also seems inappropriate to allow such incentives without any restrictions. If these incentives take the form of rewards that are best analyzed under undue inducement principles, then perhaps it could be argued that the rewards do not generally undermine voluntariness. Employees may feel less pressure to reveal disability-related information than they would if an incentive alters the size of the

205. The Bazelon Center argued that inquiry- and exam-related penalties should be entirely disallowed outside health plans while other groups argued that no limits should be applied in this context. Compare Bazelon Center Letter, *supra* note 137, at 17, with ERIC Letter, *supra* note 140, at 12-13, and Cigna, Comment on Amendments to Regulations under American with Disabilities Act 8 (June 19, 2015), <http://www.regulations.gov/contentStreamer?documentId=EEOC-2015-0006-0184&attachmentNumber=1&disposition=attachment&contentType=pdf>.

contribution they must pay to obtain health insurance. But at some point, perhaps the incentive could become sufficiently large so as to raise concerns. A ceiling would mitigate this risk.

Determining a ceiling outside of the health plan setting presents a practical challenge. In some cases, employees will be enrolled in health plans, and for these employees it seems appropriate to incorporate non-health plan-based incentives into the standard cost-of-coverage formula. If the role of the cost-of-coverage denominator is to define a reasonable limit on the total magnitude of incentives, then it seems not just appropriate, but indeed necessary, to aggregate all wellness-program incentives together, regardless of their origins.

For employees who are not enrolled in health plans, however, a cost-of-coverage equivalent will need to be found. One possibility is the employee-only cost of coverage that the employee would have had if the employee had enrolled in an employer's health plan; if the employee had a choice of several plans, the average cost of coverage might be appropriate. A commenter's suggestion points to another option: a ceiling based on the costs of the second-lowest-cost silver plan available in the employee's geographic area through an ACA exchange.²⁰⁶

An alternative approach is to abandon the tie to health plan coverage costs altogether, as discussed in Part IV.B. One of the advantages of moving to an income-based ceiling is that it would be straightforward to incorporate incentives that are not based on health plans into the formula. A fixed maximum dollar amount would similarly be straightforward to administer.

F. Summing Up

HIPAA, the ACA, and the ADA share a common objective of preventing health-related discrimination, but they differ in how they implement the objective. HIPAA and the ACA focus on discrimination within health insurance, while the ADA's focus is both narrower and broader. The ADA's focus is narrower in that it focuses specifically on disabilities, but broader in that it combats discrimination in settings that go beyond health plans. In crafting regulations that implement the wellness-program exceptions that

206. Cleveland Clinic, *supra* note 143, at 4 ("Cleveland Clinic believes that incentives for these programs should be structured similarly to group plans now, with incentives capped at 30% and up to 50% for tobacco cessation of the premium cost for the second-lowest Silver plan.").

Congress has chosen to create, regulators must take into account the statutes' distinctive goals and structures. The HIPAA-ACA exception is constrained by limits that are meant to preserve insurance affordability and avoid penalties that are too heavy. The ADA incentive ceilings should be aimed at ensuring that incentives do not render disability-related inquiries and medical examinations involuntary.

Because the HIPAA-ACA exception is directed at its core antidiscrimination provisions, which target discrimination based on disability as well as other health factors,²⁰⁷ while the ADA's exception relates specifically to inquiries and examinations, the scope of the ADA's exception should be defined independently of the ACA's. In creating the proposed rule, the EEOC did exactly that. But this essay questions whether the proposed rule's commonalities with and departures from the ACA's incentive ceiling are the best way to ensure that disability-related inquiries and medical examinations remain voluntary. This Part's analysis suggests that the ACA's cost-of-coverage-based ceiling is not necessarily a great fit for the ADA. It takes the position that the EEOC's ceiling should apply only to incentives that are contingent on responding to disability-related inquiries or undergoing medical examinations, a class of incentives that is both narrower and broader than the class of incentives subject to the ACA's ceiling. It proposes that the regulations be amended to address the situation in which employers offer incentives to employees' dependents; concerns that revealing information about dependents' disabilities might lead to discrimination against employees could be addressed by setting a higher ceiling when incentives are offered to dependents. Finally, it suggests that incentives offered outside of the health plan should be aggregated with health plan-based incentives for comparison against a single ceiling, while acknowledging the practical challenges of this approach.

The goal of the ADA's prohibition on disability-related inquiries and medical examinations was to prevent the stigma and discrimination that such inquiries could yield. A cap on incentives helps to ensure that any information provided despite these risks is supplied voluntarily. So do other forms of protection mandated by the proposed rule, such as a requirement that employers provide

207. See 29 U.S.C. § 1182 (2013).

notice describing the information to be obtained.²⁰⁸ Given the conceptual confusion and disagreement about the levels at which incentives might become coercive, it might make sense to adopt a ceiling that is broadly consistent with the relatively permissive standard of the ACA, but increase the focus on measures intended to prevent information provided to wellness programs from filtering into the workplace. Commenters have provided extensive feedback on how to better protect the information provided to wellness programs.²⁰⁹

V. CONCLUSION

The comments submitted in response to the EEOC's proposed rule evidence widely divergent views on wellness programs, wellness incentives, and their potential impacts. Some commenters expressed enthusiasm for the benefits that wellness programs and associated incentives could bring, while others expressed concern about the concentrated burdens and risks the programs could impose on individuals with disabilities. Some called for regulations that would be consistent with the HIPAA-ACA regulatory scheme, preserve flexibility, and limit administrative burden, while others called for regulations that would prohibit incentives and increase the obligations of employers to ensure that they take steps to inform employees and protect their information.

This article stakes out middle ground by focusing narrowly on the question of how to implement an incentive ceiling that would help to ensure the voluntariness of disability-related inquiries and medical examinations that are part of an employee health program. It has not considered what might constitute an "employee health program" for the purposes of the exception.²¹⁰ Nor has it considered whether the House Report's concern about the use of medical records "for the purpose of limiting health insurance" merits separate analysis.²¹¹ It has set aside questions about whether other aspects of the ADA might have implications for the operation of wellness programs.²¹² It has

208. ADA Proposed Rule, *supra* note 88, at 21,667 (proposing 29 C.F.R. § 1630.14(d)(2)(iv)).

209. Bazelon Center Letter, *supra* note 137, at 12–14; Families USA, *supra* note 138, at 7–9 (explaining how proposed confidentiality requirements fall short).

210. 42 U.S.C. § 12112(d)(4)(B) (2013).

211. H.R. REP. NO. 101-485, pt. 2, at 75 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 357.

212. *See* Bazelon Center Letter, *supra* note 137, at 17 (discussing reasonable

instead focused narrowly on voluntariness, and it concludes that while the ACA regulation is not a perfect fit, neither is a prohibition on incentives.

If the question under consideration were, “How should wellness programs be regulated to ensure that they benefit individuals with disabilities?”, or “How should wellness programs be regulated to shield individuals with disabilities from bearing unacceptable burdens?”, then the focus of the analysis would need to be much broader. Indeed, the factors involved in such an analysis would bear a very close resemblance to those actually considered in the creation of the original HIPAA regulations. This is not surprising. After all, disability is one of the health factors subject to HIPAA’s protections. Furthermore, because regulators sought to define an exception for “programs of health promotion and disease prevention,” the link between wellness programs and health was relevant to the rulemaking process.²¹³ Critics of wellness programs might argue that the Departments of Health and Human Services, Labor, and the Treasury did a poor job of striking a balance between health promotion and discrimination protections in the health plan context. If this is the case, then perhaps these regulations ought to be revisited.

In some cases, advocates and critics of wellness programs and their incentives hold different views because of differing objectives. While in theory it is possible that wellness programs benefit everyone, in practice it is likely that some employees will be left behind or even harmed. If a program yields health gains for a significant fraction of employees, but does so at the cost of imposing burdens on a smaller fraction of employees, then how should we weigh these considerations? In addition, to what extent should the potential for increased productivity be factored into policy support for wellness programs that impose burdens on certain employees?

There are also questions, however, about the extent to which wellness programs actually improve health, reduce costs, or increase productivity in the aggregate. Advocates and critics may hold different views not just because of differing objectives, but also because of differences in their assessments of the impact of wellness programs, and, in particular, wellness incentives. Evidence shows that incentives increase program participation, and that appropriately designed incentives can alter health behaviors. But this is quite

accommodation requirements).

213. See 29 U.S.C. § 1182(b)(2)(B) (2013).

different from saying that incentives that take the form typically used in wellness programs have a significant long-term impact on health, health costs, or productivity, and some studies cast doubt on or raise concerns about the benefits of wellness programs that have been adopted to date.²¹⁴ Much remains to be understood about how incentive programs function in practice, including how they impact individuals with disabilities. With more evidence, it may be possible to better tailor statutory and regulatory requirements to ensure that wellness programs are structured in ways that advance policy objectives, regardless of whether those objectives are currently embedded in the ACA, the ADA, the exceptions to these rules, or elsewhere.

As this article goes to press, stakeholders await a final rule under the ADA that is likely to establish an incentive ceiling and other requirements related to wellness programs. Stakeholders also await resolution of other hotly contested issues. One such issue is whether GINA prohibits employers from tying incentives to family members' provision of medical information; the EEOC has said that it will address this issue in future rulemaking.²¹⁵ Another issue is whether an ADA safe harbor provision for bona fide benefit plans confers legal protection on wellness programs by removing them from the reach of the prohibition on inquires and examinations.²¹⁶ One court has already found that it does,²¹⁷ but the EEOC has adopted the position that it does not.²¹⁸ The resolution of each of these issues, as well as any further action in Congress, could have a significant impact on the future of employer-sponsored wellness programs.

214. See *supra* notes 28–31 and accompanying text.

215. ADA Proposed Rule, *supra* note 88, at 21,660 n.3.

216. See Blue, *supra* note 2, at 378–81 (describing controversy over safe harbor provision).

217. *Seff v. Broward Cnty.*, 778 F.Supp. 2d 1370 (S.D. Fla. 2011), *aff'd*, 691 F.3d 1221 (11th Cir. 2012).

218. ADA Proposed Rule, *supra* note 88, at 21,662 n.24.