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Employee Wellness Programs: A Promising Vehicle to Decrease Healthcare Cost and Improve Employee Health

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INTRODUCTION

What if your employer could improve your health? What if you could not only become healthier but spend less on healthcare in the long run? Employee wellness programs attempted to answer these specific questions, improve individuals' health, and decrease healthcare costs. Wellness programs offered by employers include, for example, efforts to help employees lose weight, stop smoking, or provide lifestyle and behavioral coaching. Programs are offered through the employers group health plan, insurance provider, which the employee's and their families are a part of. Incentives to partake in these programs range from high financial incentives to gift cards and free exercise machines.[1] What was initially thought of as an innovative homerun to change the health of millions of people, quickly turned into a swing and miss for these employees and employers.

Part A will explain the original hopes and vision for implementing these programs by looking to the early history of employee wellness programs. The history of these programs will be demonstrated by the early success of the pharmaceutical company Johnson & Johnson's employee wellness program. Part A will then outline the formal adoption of these programs by the Affordable Care Act and the regulations for employers to follow when implementing and creating programs. After, part A will discuss the two different types of programs (participatory and health-contingent), different activities, and incentives used by employers. The section will then highlight the main problems that arose from these programs such as the lack of improvement in employee health, cost-shifting, and employee's concerns around their health information. To further understand the

[1] Emily Rodgers, *Top 12 Wellness Program Incentive Ideas for Your Employees*, WELLICS, https://www.wellics.com/blog/wellness-program-incentives-ideas.

impact of these problems, the section will explain the influential Illinois Workplace Study and the relevant federal rules protecting individual's health information.

Part B will highlight the current state of these programs. In Part B, the monumental case *AARP v. EEOC* will be explained followed by addressing the EEOC's current rules on incentives allowed by employers. Lastly, Part C will propose possible changes to these programs to combat the problems revealed in Parts A and B. The possible changes to these programs encompass the use of the 2013 HIPAA Amendment to employee information and a shift in focus to a personalized approach to employee's care. Additional considerations in the section address changes to the incentives allowed under these programs for employees.

By looking at the past, present, and potential for these programs, one will see that employee wellness programs can be restored to their initial intent of improving individuals' health and decreasing healthcare cost in the long run.

A. HISTORY OF THE EMPLOYEE WELLNESS PROGRAM

I. Johnson & Johnson Pharmaceutical Mogul and Employee Wellness Role Model.

Johnson & Johnson, the world-renowned health and pharmaceutical giant, was one of the first major players to take a swing at the use of employee wellness programs.[2] When the company's focus shifted from prevention of infectious disease to prevention of chronic disease, the health mogul decided to invest large sums of money to evaluate program outcomes for health risks and financial returns.[3] The first study conducted in 1980 revealed that the programs installed improved

[2] Fikry Isaac, *A Role for Private Industry: Comments on the Johnson & Johnson's Wellness Program*, 44, AM. J. OF PREVENTIVE MED., S30-S33 (2013).
[3] *Id.* at S31.

employee health, reduced inpatient healthcare spending, and decreased employee absenteeism.[4] Flash forward to 2011, the Henke Study revealed that Johnson & Johnson's annual average increase in medical drug cost was 1%, well below the 4.8% present at comparison companies.[5] The study revealed that the programs created a savings of $565 per employee annually with an average annual program cost ranging from $144 to $300 per person.[6]

Johnson & Johnson employees were invited to complete a health risk assessment.[7] Employees who have shown to have risks of concern receive a phone call from a health advisor who provides customized solutions to the employee's needs.[8] For example, solutions may include exercising at the on-site gym, joining Weight Watchers at work, or receiving one-on-one coaching from a diabetes educator.[9] The programs included a holistic healing approach which includes sessions with on-site fitness professionals and "relaxing sessions" with a counselor.[10] Employees were also taught about managing their time and energy and pursuing short-term goals that include healthful practices.[11]

From the years 1995-1999 and again in 2007-2010, employees who exhibited key risk factors declined significantly.[12] Employees who used tobacco dropped from 12% to 3.8% while employees with high blood pressure dropped from 14% to 6.1%.[13] From the years 2006 – 2010,

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[4] *Id.*
[5] *Id.*
[6] *Id.* at S32
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*

employees who were deemed to be at "low-risk" (meaning they exhibited 0-2 risk factors for various health conditions) increased from 78.1% to 87%.[14]

Other big-name companies followed suit such as Bank of America, California Public Employees Retirement System, and Citibank Health Management Program to create similar programs.[15] Johnson & Johnson's employee wellness programs stood as a model to the healthcare industry as a vessel to improve health and decrease cost. The program showed the promise that improvement was possible and achievable.

II. The ACA Steps In.

During the Obama administration, The Patient Protection and Affordable Care Act (ACA) formally enacted the use of employee wellness programs to lower the costs to employers who provide health insurance for their employees. ACA §2705 provides employers with guidelines to adopt and administer wellness programs.[16] The Act states that the program offered by an employer must be "designed to promote health or prevent diseases."[17]

The most contested requirement, which will be discussed later, is subsection (j)(3)(A). The statute states that incentives for the programs that require "satisfaction of a standard related to a health status of factor, shall not exceed 30% of the cost of employee-only coverage under the

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[14] *Id.*
[15] Camila Strassle & Benjamin E. Berkman, Article: *Workplace Wellness Programs: Empirical Doubt, Legal Ambiguity, and Conceptual Confusion*, 61 WM. & MARY L REV. 1663, 1668 (2020); Janet L. Bly et al., *Impact of Worksite Health Promotion on Health Care Costs and Utilization*, 256 J. AM. MED. ASS'N 3235, 3237-32340 (1986).
[16] 42. U.S.C.S. §300gg-4.
[17] *Id.*

plan."[18] The reward for the programs "may be in the form, of a discount or rebate of a premium contribution, a waiver of all or part of a cost-sharing mechanism."[19]

Section (j)(2) outlined exceptions to the rule for programs which did not need to be subject to the requirements of (j)(3).[20] The exempted programs in (j)(2) are not based on the individual satisfying a standard related to health status factors.[21] Those programs are to be made available to all similarly situated individuals.[22] They include: (A) programs that reimburses all or part of a membership in a fitness center, (B) diagnostic testing with a reward for participation, (C) program that encourages preventive care related to health conditions through the waiver of the copayment or deductible requirement, (D) program that reimburses individuals for the cost of smoking cessation programs without regard to whether the individual quits smoking, and lastly (E) program that provides a reward to individuals for attending a periodic health education seminar.[23]

Over time, employers took to these programs like fish to water. As of 2019, 84% of large employers, meaning those with 200 or more workers, who offered health benefits additionally offered a form of workplace wellness program.[24] The programs offered by employers encompassed various types of services and activities such as health risk assessments (HRAs), biometric screenings, disease management programs, weight loss programs, gym membership discounts, smoking cessation programs, nutrition classes, and web-based resources for healthy living.[25] These

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[18] *Id.* at (j)(3)(A).
[19] *Id.*
[20] *Id.* at (j)(2).
[21] *Id.*
[22] *Id.*
[23] *Id.* at (A-E).
[24] Karen Pollitz, *Trends in Workplace Wellness Programs and Evolving Federal Standards*, KAISER FAM. FOUND., (Jun. 9, 2020) https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards.
[25] *Employer health benefits*, KAISER FAM. FOUND. AND HEALTH RSCH. & EDU. TR. (Sept. 22, 2015), https://www.kff.org/health-costs/report/2015-employer-health-benefits-survey/.

programs were divided into two categories, health-contingent wellness programs or participatory wellness programs. Health-contingent programs reward participants for achieving or meeting a pre-determined health-related metric.[26] Participatory wellness programs reward employees for engaging in employer-sponsored activities that are aimed at improving health.[27]

The biometric screenings and health risk assessments (HRAs) used by employers for both participatory or health-contingent programs consist of in-person medical examinations such as blood tests to measure risk factors for potential health conditions like blood pressure, cholesterol issues, stress, nutrition, and body weight. [28] Additionally, employers would use data collected from these screenings and assessments to mold and target specific activities offered in the wellness programs based off employee's specific risk conditions.[29]

The passing of Section (j)(3) created a promising "white knight" to combat raising healthcare cost and improve the health of millions of Americans. As we will discuss in the next section, the use of these programs revealed little to no improvement in health and created a plethora of problems for employee's disclosure of personal health information.

III. Program Results, Problems, and litigation.

This section discusses the various problems revealed with the use of employee wellness programs. The use of employee wellness programs revealed little improvement in employee's

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[26] Lindsay F. Wiley, *Access to Health Care as an Incentive for Healthy Behavior? An Assessment of the Affordable Care Act's Person Responsibility for Wellness Reforms*, 11 IND. HEALTH L. REV. 635, 686 (2014).
[27] *Id.*
[28] *Employer Benefits*, KAISER FAM. FOUND. AND HEALTH RSCH. & EDU. TR. (Sept. 16, 2016) https://www.kff.org/health-costs/report/2016-employer-health-benefits-survey/.
[29] *Id.*

health, caused cost-shifting to employees with serious health issues or needs, and raised ethical and legal concerns surrounding the use of employee data.

A. Lack of improvement in health

Studies were conducted to put the theory of these programs to test. Were the programs as successful as the Johnson and Johnson program was? Were wellness programs truly reducing cost and improving health? Unfortunately, various studied revealed little to no improvement to an employee's physical health. Though wellness programs are designed to incentivize individuals to take personal responsibility for their health behaviors, the programs have done little to address the underlying social determinants of health that lead to those unhealthy behaviors, making it difficult to see lasting improvement in one's health.[30] Additionally, Studies revealed that those who were actively participating were already considered "healthy."[31]

One famous clinical trial conducted at University of Illinois at Urbana-Champaign (UIUC), known as and here by referred to as the Illinois Workplace Study, revealed ground-breaking results that a comprehensive workplace wellness program had no significant effects on measured physical health outcomes over the course of the two year trial.[32]

The trial was designed to investigate the effects of workplace wellness programs on employee medical spending, productivity, and well-being.[33] The trial consisted of a comprehensive wellness program titled, iThrive.[34] iThrive consisted of three main components: annual on-site

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[30] *See generally* Angela P. Harris &Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758 (2020).
[31] *Id.*
[32] *See generally* Damon Jones, David Molitor, & Julian Reif, *What do Workplace Wellness Programs do? Evidence from the Illinois Workplace Wellness Study,* 134 Q.J. OF ECON., 1747-1791 (2019).,
[33] *Id.*
[34] *Id.* at 1749.

biometric health screening, annual online HRA, and weekly wellness activities.[35] Of the 4,834 participants in the program, 3,300 were assigned to the treatment group and given paid time off to participate in the wellness program activities.[36] The remaining 1,534 participants were assigned as the "control group" and did not participate in any of the components of iThrive.[37]

The first step for those participating in iThrive was to complete a biometric health screening and an online HRA offered at one of the many location sites on the university campus.[38] A few days after completing the screening participants were sent via email another online HRA focused on their lifestyle habits.[39] Step two of iThrive consisted of participation in various wellness activities.[40] The activities offered consisted of in-person classes on chronic disease management, weight management, tai chi, physical fitness class, financial wellness, and healthy workplace habits.[41] The program also offered a tobacco quit line (cessation program) and online, self-paced wellness challenges.[42] These classes and programs were offered for 6-12 weeks and in both the fall and spring semester.[43]

Participants were offered monetary rewards for the "completion" of specific activities.[44] The study defined "completion" of a class as attending at least three-fourths of the sessions in a semester.[45] The monetary rewards varied based off of the treatment group an individual was

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[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.* at 1756.
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*

assigned to.[46] For example, if a participant completed the biometric screening and HRA, they could receive anywhere from $0 to $200 depending on which treatment group they were assigned.[47] Treatment groups were further divided based off financial incentives for the wellness activities.[48] Of the six subdivided groups, participants could receive anywhere from $50-$350 for completing all components of the wellness program after the first year depending on which treatment group they were in.[49]

After the first 12 months, reports showed that 56% of participants in the treatment group completed both the health screening and online HRA.[50] The 44% who did not complete the screenings were not able to move to step two the participation in wellness activities.[51] In the fall semester, of those eligible to participate in the wellness activities only 27.4% completed enough of the activity to earn their assigned activity reward.[52] In the spring semester only 22.4% completed the wellness activities.[53] Second year participation rates followed a similar pattern, although the level of participation decreased for all activities which could be due to job turnover and smaller size of the offered rewards.[54] For the second year of the study, the basic structure remained the same, however, smaller incentives were offered.[55]

The results concluded that the iThrive wellness program increased health screening rates but had no effects on medical spending, health behaviors, or employee productivity.[56] After just

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[46] *Id.*
[47] *Id.*
[48] *Id.* at 1757.
[49] *Id.*
[50] *Id.* at 1766.
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.* at 1767.
[55] *Id.*
[56] *Id.* at 1788.

12 months, there was no significant effects on average medical spending and no significant effects on various employment and productivity outcomes.[57] One exception is that individuals in the treatment group were 7.2% more likely to believe that management places a priority on health and safety.[58] There were small insignificant effects on health behaviors, such as the average number of days an employee visits a campus recreation facility.[59]

The study found no effects as to monetary incentives success to promote exercise or participation in the programs.[60] The researchers noted that one potential explanation for the disappointing results could be that those who would benefit the most (e.g. smokers and those with high medical cost) declined to participate even when they were offered large monetary incentives.[61]

The results of the Illinois workplace study parallel the results many employers found.[62] The implementation of these studies showed little to no impact on employee health or health cost.

B. Cost-Shifting

An additional issue revealed through these programs was cost-shifting. The Illinois Workplace wellness study found that the employees who chose to participate in the programs were less likely to be in the bottom quartile of the income distribution.[63] These wealthier participating employees had lower medical spending and healthier behavior prior to the program compared to nonparticipating employees[64] The results mirrored what was occurring in other wellness programs,

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[57] *Id.* at 1776-1777.
[58] *Id.* at 1778.
[59] *Id.* at 1779.
[60] *Id.* at 1788.
[61] *Id.*
[62] Strassle, *supra* note 15, at 1674.
[63] *Id.* at 1771.
[64] *Id.*

the cost of healthcare was shifting to employees of low-income, high health care spending, and poor health habits.[65]

Due to healthier and wealthier individuals choosing to participate combined with the use of financial incentives to motivate workers, employee's with disabilities, low-income individuals, and racial minorities have become disproportionately burdened because these groups are more likely to be affected by the health risks and conditions that wellness programs target.[66] The health-contingent programs worked to reward healthy individuals and penalize what the employer deemed "unhealthy" individuals.[67] The contingent programs that require participants to satisfy a standard related to a specific health factor through either (1) activity-only programs such as walking, diet, or exercise; or (2) outcome-based programs such as quitting smoking or attaining a certain result on a biometric screening, were mainly completed by individuals who already obtained the set health metric or regularly participated in healthier habits.[68]

When employers condition financial incentives or penalties on meeting health criteria, individuals who are unable to meet those criteria are then forced to pay higher cost.[69] Using discrimination on the basis health status, "healthism," as a way to encourage people to be healthy

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[65] *Id.* at 1788.
[66] *See generally* Jennifer Dianne Thomas, Comment, *Mandatory Wellness Programs: A Plan to Reduce Health Care Costs or a Subterfuge to Discriminate Against Overweight Employees?*, 53 HOW. L.J. 513 (2010).
[67] Emily Koruda, Article: *More Carrot, Less Stick: Workplace Wellness Programs & the Discriminatory Impact of Financial and Health-Based Incentives*, 36 B.C.J.L. & SOC. JUST. 131, 141 (2016).
[68] *HIPAA and the Affordable Care Act Wellness Program Requirements,* DEP'T OF LABOR, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/caghipaaandaca.pdf
[69] Anya E.R. Prince, Article, *Hidden Trade-Offs in Insurance Wellness Programs*, 2021 MICH. ST. L. REV. 341, 346 (2021); *Discussion of Notice of Proposed Rulemaking on Wellness Programs-Transcripts*, U.S. EQUAL EMP. OPPORTUNITY COMM'N (June 11, 2020), https://www.eeoc.gov/meetings/meeting-june-11-2020-discussion-notice-proposed-rulemaking-wellness-programs/transcript (quoting Commissioner Burrows presenting at the meeting).

assumes that individuals are "unhealthy" due to reasons within their control.[70] Due to socioeconomic failures including limited access to healthy and affordable food, or even limited time to exercise, the health of many low-income workers and workers of color are extremely impacted.[71] Historically, people of color are disproportionately affected by factors that are the main targeted of wellness programs like stress, high blood, pressure, and diabetes.[72]

The programs in place by employers tied with the incentives caused a cost-shifting to employees who were unable to meet the required health metrics. Those who had high medical costs, and were disproportionality effected by health factors due to social determinants of health were left to bear the burden of the already high medical costs.

C. ADA And GINA Concerns

Employees became concerned due to the required disclosure of their private health information for specific programs. As mentioned earlier, the information collected from these screenings for participatory or health-contingent programs is used by employers to formulate programs for risk conditions seen in the employees. The disclosure of information was required for participation and receiving of high incentives for specific health-contingent programs blurring the line between what is "voluntary" or "involuntary." This section focuses on the information collected from employees HRAs, biometric screenings, and health screenings used by employers.

The Employee Benefits Research Institute conducted a survey to evaluate how employees feel about disclosing health information to their employer.[73] The results showed that 33% of employees

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[70] Jessica L. Roberts & Elizabeth Weeks, *Healthism: Health-Status Discrimination and the Law*, 9, CAMBRIDGE UNIV. PRESS (2018) ("Healthism" is the discrimination of individuals on the basis of health status.)
[71] Anya, *supra* note 69, at *Id.*
[72] *Id.*
[73] Erica Che, Note: *Workplace Wellness Programs and the Interplay Between the ADA's Prohibition on Disability-Related Inquires and Insurance Safe Harbor*, 2017 COLUM. BUS. L. REV. 280, 290 (2017); Paul Fronstin, *Findings*

who declined to participate did so because they were concerned that their employers would learn their personal health information.[74] Historically, the disclosure of this information has been protected under federal regulations such as the Health Insurance Portability and Accountability Act - HIPAA, the American with Disabilities Act - ADA, and the Genetic Information Discrimination Act - GINA. To better understand how these regulations interact with employee wellness programs, we must first understand what is protected and how it is protected under these regulations.

i. What is HIPAA, ADA, and GINA?

The Health Insurance Portability and Accountability Act of 1996, uniformly known as HIPAA, was created to protect sensitive patient information from being disclosed without the patients consent or knowledge.[75] HIPAA Privacy rules set standards for individual's rights to understand and control how their health information is used in order to balance the protection of health information with the need for information to promote high-quality healthcare.[76] The application of HIPAA to workplaces wellness programs depends on the structure of the program itself. If a workplace wellness program is offered as part of a group health plan or insurance, an individual's health information collected from or created about participants in the wellness program is protected by HIPAA.[77] If an employer offers the program directly, the information collected by an employer is not protected under HIPAA.[78]

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from the 2013 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, EMP. BENEFIT RESEARCH INST. 17 (2013).

[74] *Id.*

[75] *Health Insurance Portability and Accountability Act of 1996 (HIPAA*), CTR. FOR DISEASE PREVENTION AND CONTROL (Reviewed June 27,2022) https://www.cdc.gov/phlp/publications/topic/hipaa.html.

[76] *Id.*

[77] *HIPAA Privacy and Security and Workplace Wellness Programs*, U.S. DEP'T. OF HEALTH AND HUM. SERV. (Reviewed April 20, 2015), https://www.hhs.gov/hipaa/for-professionals/privacy/workplace-wellness/index.html.

[78] *Id.*

A 2013 amendment to HIPAA, known as Incentive for Nondiscriminatory Wellness Programs in Group Health Plans, contained final regulations to provide consistency with the ACA for permissible rewards under a health-contingent wellness program for a group health plan.[79] The amendment increased incentives to 30% of the cost of employee coverage.[80] The amendment itself defines health-contingent wellness programs as activity-only wellness programs, and outcome-based wellness programs.[81]

The Americans with Disabilities Act, ADA, was enacted in 1990.[82] ADA was enacted to allow equal opportunity to people with disabilities who were historically excluded from many aspects of civic life.[83] The Act prohibits discrimination against individuals with disabilities in areas of public life such as jobs, schools, transportation, and both public and private places open to the general public.[84] The Americans with Disabilities Act Amendments Act (ADAAA) was signed into law in 2008, which amended the definition of disability to apply to all titles of ADA.[85] For purposes of this article we will highlight Title I, Equal Employment Opportunity for Individuals with disabilities. The general rule is that "no covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application, hiring, advance, or discharge of the employee…"[86]

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[79] 78 FR 33158.
[80] *Id*.
[81] *Id.*
[82] *What is the Americans with Disability Act (ADA)?*,ADA NAT'L NETWORK (Updated April 2023), https://adata.org/learn-about-ada.; 42 U.S.C. §§12112.
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] 42 U.S.C. §12112(a).

Title I was designed to help individuals with disabilities access the same employment opportunities and benefits available to those without disabilities.[87] Under this, an employer with 15 or more employees must provide reasonable accommodations to disabled employees that will enable the employee with a disability to participate in the application process or to perform the essential functions of the job.[88] The Act does contain some exceptions to allow medical inquiries if the examination or inquiry is shown to be job-related and consistent with the business necessity, or the inquiry is voluntary.[89] The term "Voluntary" is not defined in the statute.

The Genetic Information Nondiscrimination Act, GINA, protects against discrimination on the basis of genetic information.[90] The statute was enacted by Congress with the purpose to alleviate individual's anxieties about genetic testing by prohibiting health insurers from using genetic-results and family individual's medical history to discriminate against the individual.[91] Genetic information protected by GINA includes an individual's genetic tests, genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual.[92] The term "genetic information" does not include information pertaining to an individual's sex or age.[93]

B. CURRENT STATE OF EMPLOYEE WELLNESS PROGRAMS

IV. Current Federal Regulations Intertwined with The EEOC'S Definition of "Voluntary."

[87] *Id.*
[88] *Id.*
[89] *Id.* at (d)(4)(A) and (B).
[90] *See generally* Bradley A. Areheart & Jessica L. Roberts, Article: *GINA, Big Data, and the Future of Employee Privacy*, 128 YALE L.J. 710 (2019).
[91] *Id.* at 716.
[92] 42 U.S.C. §200ff.
[93] *Id.* at (4)(C).

Litigation arose surrounding the definition "voluntary" in the space of employee wellness programs. Challengers argued that the use of incentives for the programs were inconsistent with the definition of "voluntary" for the ADA and GINA requirements. In 2016, the EEOC, Equal Employment Opportunity Commission, attempted to provide guidance to employers as to what constitutes "voluntary." An employee health program that includes disability-related inquiries or medical examinations (including those for HRAs) is considered voluntary as long as a covered entity:

i. Does not require employees to participate;
ii. Does not deny coverage under any of its group health plans or particular benefits packages within a group health plan for non-participation, or limit the extent of benefits for employees who do not participate;
iii. Does not take any adverse employment action or retaliate against, interfere with, coerce, intimidate, or threaten employees within the meaning of section 503 of the ADA; and
iv. Provides employees with notice that:
    a. Is written so that the employee from whom medical information is being obtained is reasonably likely to understand it;
    b. Described the type of medical information that will be obtained and its specific purposes for which it will be used; and
    c. Described the restrictions on the disclosure of the employee's medical information, the employer representative or other parties with whom the information will be shared, and the methods that covered entity will use to ensure the medical information is not improperly disclosed (including whether it complies with the measures set forth in the HIPAA regulations codified at 45 CFR part 160 and 164).[94]

Though on its face the requirement appears to provide a nonthreatening, noncoercive definition of "voluntary," the EEOC guidelines simultaneously increased the maximum allowable incentive rate to 30% for employee participation in programs.[95]

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[94] 29 C.F.R. 1630.14(d)(2).
[95] Andrew Condiles, Article: *How voluntary is voluntary: Designing Wellness Programs To Fit The Participant*, 18 APPALACHIAN J.L. 1(2018/2019); *citing* 29 CFR §1630.14(d)(3) [reversed].

The 30% incentive aided in the cost-shifting issue as described above. Employees with severe health risks and medical necessities felt coerced to either disclose their information or be responsible to make up cost for employees who were willing and able to disclose their health information. Unfortunately, in many cases, the judicial system sided with employers whose programs required disclosure for moderate incentives voluntary.[96] Courts have found that "light burdens" such as taking a blood test or completing questionnaires were not coercive and did not violate other federal regulations.[97]

In 2016, *AARP v. U.S. EEOC* attempted to addressed what is defined as "voluntary" in the wellness program context. The central issue of the case was around the tension between the goals of employee wellness programs and the interests of the ADA and GINA.[98] Litigation focused on the 30% incentive amount offered by employers in exchange for participation of the employee wellness programs.[99]

While HIPAA and its regulations expressly permit the use of incentives in wellness programs, the uncertainty looked to whether the "voluntary" definitions of the ADA and GINA permit the use of incentives in wellness programs that implicate or require ADA or GINA protected information.[100] The court needed to address if the EEOC decision to interpret the term "voluntary"

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[96] *Id.* at 9.
[97] *Id.; Provance v. Gallatin County*, 2015 WL 1810307 (D. Mont. 2015) (holding that an employer who offered a voluntary wellness program requiring employees to partake in blood screening to receive a waiver of $50.00 off their monthly premium did not violate the ADA voluntary requirement.)
[98] *Id.* at 10.
[99] *See AARP v. EEOC*, 267 F. Supp. 3d 14 (D.C. 2017).
[100] *Id.* at 20.

to permit a 30% incentive level is reasonable and whether the agency has offered an adequate explanation for the interpretation in both the ADA and GINA context.[101]

As to the ADA context, the EEOC reasoned its choice to allow up to 30% of cost of the self-only coverage was adopted (1) to harmonize with the HIPAA regulations governing wellness programs, (2) because the 30% incentive level is a reasonable interpretation of "voluntary" based on "current insurance rates," and (3) a comment letter submitted by the American Heart Association endorsed the 30% level.[102] The court concluded that the EEOC had not provided reasoned explanations for its conclusion that the 30% incentive is the appropriate measure for voluntariness.[103]

The 30% incentive does not harmonize with HIPAA because the incentives for health-contingent wellness programs are the exception to the rule; insurers and health plans are essentially allowed to discriminate based on health factors in certain limited circumstances.[104] The court stated that the EEOC did not explain why it would make sense to adopt a wholesale 30% level from HIPAA, which was adopted in a different statute based on different reasons, to the ADA context as a permissible interpretation of the term "voluntary."[105] The reasoning that the decision was based on insurance rates contained no study as to the analysis of the "current insurance rates" nor did the EEOC elaborate what these rates are and how they were evaluated.[106] The comment letter submitted by the American Heart Association does not explain why the 30% is an appropriate level measure of voluntariness and even cautioned in the letter that, "it is not intuitive that a program is

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[101] *Id.* at 27.
[102] *Id.* at 29.
[103] *Id.*
[104] *Id.* at 30.
[105] *Id.* at 31.
[106] *Id.*

completely voluntary with an incentive attached that can significantly increase the cost of health insurance."[107] Because of the lack of reasoning and the EEOC's failure to show they had considered factors that actually speak to whether a given incentive level is voluntary or coercive, the court concluded that the EEOC's interpretation of the ADA's voluntariness requirement is neither reasonable nor supported by administrative record.[108]

The 30% incentive extended to the disclosure of an employee's spouse's manifestation of disease and disorder, medical history, but did not permit employers to use incentives to collect information about the spouse's genetic information or that of the employee's child.[109] AARP argued that this provision would be inconsistent with GINA because it would allow protection to only one type of information and not the other.[110] According to AARP, this would make the GINA rule inconsistent because the meaning of "voluntary disclosure with respect to spousal information" compared to the meaning of "voluntary disclosure referring to genetic information" would then allow incentives for one type of information and the other meaning would not allow for incentives of any information.[111]

The court was not convinced that the EEOC's decision to distinguish between different types of genetic information and other types of information entitled to incentives would render the rule unreasonable or inconsistent with GINA.[112] The court, however, did not agree with the EEOC's reasoning for distinguishing the two types of information.[113] The EEOC argued that there

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[107] *Id.* at 32.
[108] *Id.* at 34.
[109] *Id.* at 35.
[110] *Id.* at 34.
[111] *Id.* at 35.
[112] *Id.*
[113] *Id.*

was less risk of employer discrimination based on spouse's medical history because the spouse's medical history does not reveal actual genetic information about the employee and cannot be used to make predictions about an employee's health.[114] The court concluded that discrimination on the basis of health status or genetic information is still likely to occur due to the potential increase for insurance costs to the employer because of the dependents covered on an employee's health plan.[115] The 30% incentive failed for the same reasons as it failed in the ADA context, the EEOC presented little evidence that analyzed any factors that might be relevant to the economic "coerciveness" of an incentive level in interpretating "voluntary" in the GINA rule.[116]

Neither the rules nor the administrative records contained concrete data, studies, or analysis that would support why the 30% incentive is the threshold amount or how past that amount an incentive would become involuntary in violation of the ADA and GINA.[117] As for the remedy, the court found it best to remand the rules to the EEOC for reconsideration without vacating the rule completely.[118]

V. Employers Current Employee Wellness Programs.

Currently, the 30% incentive cap is still allowed to be used by employers. In January of 2021, the EEOC proposed a new rule for incentives.[119] The EEOC proposed that in order to comply with both the ADA and GINA, employers may offer no more than a "de minimis" incentive to encourage the participation in wellness programs.[120] "De minimis" incentives would be incentives

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[114] *Id.*
[115] *Id.*
[116] *Id.* at 36.
[117] *Id.* at 37.
[118] *Id.* at 38.
[119] *EEOC Provides Proposed Wellness Rules for Review*, U.S. EQUAL EMP. OPPORTUNITY COMM'N (1/1/2021), https://www.eeoc.gov/newsroom/eeoc-provides-proposed-wellness-rules-review.
[120] *Id.*

of very little value such as a mug, or gift card.[121] This new rule would not apply to wellness programs that would be permitted to offer the maximum incentive allowed under the 2013 HIPAA regulations.[122]

Shortly after the proposed rule was released, the Biden Administration issued a regulatory freeze memorandum.[123] Due to the freeze, the EEOC announced that the proposed regulations had been withdrawn and was promptly removed from the EEOC's website.[124] As of now, the next steps by the EEOC are stated as "under consideration."[125]

As of 2022, 55% of large firms who offered health benefits offered workers the opportunity to complete a health risk assessment, 45% offered a biometric screening, and 85% offered wellness programs to help employee quit smoking, lose weight, or offered lifestyle and behavioral coaching.[126] Firms still use incentives for the completion of these programs. The financial incentives offered range from $150 or less, to $2,001 or more.[127]

As for the results of these programs on reducing health care costs, on a scale from "very effective" to "did not know," only 9% of the firms said their programs were "very effective" at reducing the cost of health care while 42% said the programs were "only slightly effective."[128]

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[121] Stephen Miller, *EEOC Proposes – Then Suspends Regulations on Wellness Program Incentives*, SOC'Y FOR HUM. RES. MGMT. (January 13, 2021) https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/eeoc-proposes-new-limits-on-wellness-program-incentives.aspx.
[122] *EEOC Provides Proposed Wellness Rules for Review*, *supra* note 119.
[123] *EEOC Withdraws Proposed Regulations Addressing ADA and GINA Wellness Program Incentives,* THOMSON REUTERS (Feb. 25, 2021), https://tax.thomsonreuters.com/blog/eeoc-withdraws-proposed-regulations-addressing-ada-and-gina-wellness-program-incentives/.
[124] *Id.*
[125] *Id.*
[126] *2022 Employer Health Benefits Survey*, KAISER FAM. FOUND. (Oct. 27, 2022) https://www.kff.org/report-section/ehbs-2022-section-12-health-screening-and-health-promotion-and-wellness-programs/.
[127] *Id.* at Figure 12.14.
[128] *Id.*

When asked about reducing health care utilization, the need to use health care services, 6% said their programs were "very effective" and 34% stated the programs were "only slightly" effective.[129]

Though employers have attempted to evolve incentives such as offering apple watch's, paying for gym memberships, and offering potentially large monetary incentives, the results of these programs are still not achieving their goal. Should these programs be tossed into the trash, or can they be revamped to reach the results they intended for?

C. NORMATIVE IMPLICATIONS TO EMPLOYEE WELLNESS PROGRAMS USING HIPAA PROTECTION AND A PERSONALIZED APPROACH

These programs have the potential to positively impact employee's health. To protect employee information and ease employee's worries while encouraging participation, information for these programs should be handled and kept by the insurance companies of the group health plans thus covered under the 2013 Amendment. To see improvements in employee's health in the long-term, employer's group health plans should take a personalized approach and incorporate personalized medicine for prevention and treatment of an employee's health needs.

VI. Employee Protection using the 2013 HIPAA Amendment.

As stated, an individual's medical information is protected under HIPAA and allowed for the use of health-contingent wellness programs. By restricting the handling of information to just the insurance providers, employers can rectify the concerns of employees of being discriminated against for their disability or health status. As opposed to employers providing programs directly

[129] *Id.*

or the insurer providing programs, the insurance company can act as a vehicle for the employer to administer, collect information, and oversee employees needs for the programs.

How would this work? Insurance providers are allowed by law to issue individual's diagnostic testing and HRA's to understand an individual's health.[130] The insurance company hired by the employer can request and store the tests results collected from employees. If an employer would like to offer a specific participatory wellness program, the information collected from the employers can be handled internally by the insurance company. Essentially, the administration of the program would be covered under the 2013 HIPAA Amendment.

Employers are allowed limited information collected by these tests to create participatory wellness programs that better suit the needs of their employers. Should an employer want to inquire information to formulate voluntary programs for their employees, the insurance company would be the entity to administer and collect the information. The results collected can be shared with the employer in a way as to not identify employees, but strictly reveal the needs by the large population of employees. The strict administering from the insurance provider could ease employees' minds that their information is protected by legal regulations and not disclosed to their employer.

VII. Personalized Approach to Employee's Health Using Personalized Medicine.

Taking an individualized approach and incorporating personalized medicine, health-contingent programs will likely see improvement in individuals' health. Personalized medicine, also referred to as precision medicine, is the "tailoring of medical treatment to the individual

[130] *Security Risk Assessment Tools*, HEALTHIT.GOV, https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool.

characteristics of each patient."[131] Personalized medicine encompasses the use of risk assessments, prevention, detection, diagnosis, and treatment.[132] This approach to treatment contrasts the one-size-fits all approach to medicine by looking to the individual's environment, genetics, and lifestyle.[133] Personalized medicine allows health care providers to customize disease-prevention strategies, prescribe more effective drugs, and preempt disease progression.[134] In the employee wellness setting, personalized medicine can be used to provide treatment better suited for the needs of individual employees. Personalized medicine will also rectify the issue of statistically healthier people partaking in the wellness programs and shifting the cost to "unhealthy" individuals.

This approach would mirror the Johnson & Johnson program which used health advisors to create a personalized health approach to employer's needs. As previously stated, the information needed would be between the employee and physician covered by the group health plan as to not raise privacy concerns. For example, an employee undergoes a HRA provided by their physician, under the employer health program, which shows the employee is at risk for skin cancer due to high sun exposure and genetics. If the employee attends their yearly screenings, the employee can receive a discount on their premiums. The use of the incentive would be tailored to the individual need of the employee and the information would be contained to the insurance company.

Focusing on personalized medicine combined with incentives, can combat the cost-shifting to employees with medical needs. Upon working with the physicians covered within the group

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[131] *The Age of Personalized Medicine*, PERSONALIZED MED. COALITION, https://www.personalizedmedicinecoalition.org/userfiles/pmc-corporate/file/pmc_age_of_pmc_factsheet.pdf.
[132] *Id.*
[133] *What is Precision Medicine?* NAT'L LIBR. OF MED., (May 17, 2022), https://medlineplus.gov/genetics/understanding/precisionmedicine/definition/.
[134] *What are the benefits of precision medicine?,* THE JACKSON LAB'Y., https://www.jax.org/personalized-medicine/precision-medicine-and-you/what-is-precision-medicine.

health program, employees will be eligible for the 30% incentive so long as they fulfill the requirements for their instructed care by their physician. This approach can also ensure that those individuals with health needs are receiving care for their specific need. For example, an employee who needs to attend physical therapy due to a hip injury could be eligible for the incentives as long as they attend their appointments. This could be measured by a set amount of visits an individual needs to attend per year recorded by the physician and communicated to the insurance company.

The participatory wellness programs can be used to address social determinants[135] that effect employee's health to better ensure improvement in health. Using the information provided by the insurance providers, employers can narrow down which social determinants impact most employees. If a vast number of employees are unable to provide healthy food options for themselves and their families, employers could host farmers markets on workplace grounds to provide the employees an opportunity to have access to fresh, healthy produce. If results show that employees feel that do not have time for physical activities, employers can incentives employees to go on walks during breaks or provide on-site opportunities for exercise. The participatory programs would still follow the requirements of section (j)(B) as being open to all employees and individual's information would not be disclosed to the employer.

VIII. Additional Considerations.

In considering the use of incentives for participatory programs, statistics are split as to if financial incentives motivate employee participation. The EEOC recommendation of "de minimis"

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[135] Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. (May 10, 2018), https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-healthequity (Social determinants of health are conditions in which people are born, grow, live, work, and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.)

incentives could run the risk of providing such a small incentive that there is zero motivation to complete the program. The EEOC should not completely rule out a numbered percentage to incentives participatory programs but would need to conduct in-depth financial analysis to find the middle ground as to what amount would still motivate but not cause a severe cost-shifting.

The court in *AARP v. U.S. EEOC* did not completely condemn the use of incentives. The court strictly held that EEOC did not provide sufficient reasoning or facts to show the 30% incentive was threshold amount for "voluntary." Due to contradicting data and EEOC's lack of in-depth analysis, incentives for participatory programs should still be taken into consideration but evaluated through further research as to an amount that would still be voluntary and not cause severe cost-shifting.

D. CONCLUSION

Employee wellness programs have the potential to positively impact individuals lives and reduce healthcare cost over time. The administering and collection of program information by insurance providers would protect employee information and ease their minds as to the threat of discrimination from their employer. Introducing personalized medicine and providing ways to combat the social determinants of health impacting employees will help to provide individual specific care, prevent cost-shifting, and see improved results in the long run. These recommendations can put employee wellness programs back on track to improve individuals' health and decrease healthcare cost.