WORKPLACE WELLNESS PROGRAMS AND THE INTERPLAY BETWEEN THE ADA'S PROHIBITION ON DISABILITY-RELATED INQUIRIES AND INSURANCE SAFE HARBOR

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The EEOC's May 2016 final rule on employer wellness programs, along with two recent rulings by courts in Wisconsin, reflects the growing pains of a legal doctrine developing under the Americans with Disabilities Act ("ADA") regarding the application of the statute's provisions to wellness program requirements. This Note evaluates how ADA provisions should apply to two common components of workplace wellness programs, health risk assessments and biometric screenings, and the use of incentives by employers to increase employee participation in such programs. In particular, this Note examines the interplay of the ADA's restrictions on medical examinations and inquiries, its exception for examinations and inquiries that are part of "voluntary" employee health programs, and its insurance "safe harbor" provision. After outlining inconsistencies in the application of the ADA's provisions in recent "safe harbor" cases, this Note aims to clarify the debate and build on the EEOC's new regulatory guidance by providing a comprehensive analysis of the ADA's limits on health screening programs.

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I. INTRODUCTION

Two recent rulings by courts in Wisconsin and the EEOC's May 2016 regulations regarding wellness program incentives display the growing pains of a legal doctrine developing under the Americans with Disabilities Act ("ADA") regarding the application of the statute's provisions to wellness program requirements. This Note evaluates how ADA provisions should apply to two common components of workplace wellness programs, health risk assessments and biometric screenings, and the use of incentives by employers to increase employee participation in such programs. In particular, this Note examines the interplay of the ADA's restrictions on medical examinations and inquiries, its

exception for examinations and inquiries that are part of "voluntary" employee health programs, and its insurance "safe harbor" provision. The Note examines how the EEOC's new regulations and regulatory guidance on the permissibility of wellness incentives may not fully resolve the ADA's limits on the types of practices at issue in recent "safe harbor" cases and proposes a framework of analysis for applying the ADA's provisions to health screening programs.

Part II of the Note describes the characteristics of workplace wellness programs and provides an overview of the legal regime governing wellness incentives. Part III outlines inconsistencies in the application of the ADA's provisions in recent cases and compares arguments by employers, plaintiffs, and the EEOC on how to treat wellness programs under the ADA. Part IV analyzes questions and arguments left unaddressed by the case law and the EEOC's recently issued regulation governing wellness incentives and suggests an integrated approach for applying the ADA to wellness programs.

II. BACKGROUND ON WELLNESS PROGRAMS AND RELEVANT LAWS

While wellness programs are not new to the workplace,[1] their popularity has increased in recent years, a trend reflecting employers' efforts to reduce healthcare costs and to

[1] Many employers began offering wellness programs in the 1980s, including programs involving blood pressure control, weight control, stress management, nutrition, and smoking cessation. Kristin Madison, *Employer Wellness Incentives, the ACA, and the ADA: Reconciling Policy Objectives*, 51 WILLAMETTE L. REV. 407, 411–13 (2015) (providing an overview of the history and early growth of workplace wellness programs). According to a survey by the Bureau of Labor Statistics, approximately 82% of full-time employees in the public and private sectors had access to a wellness program in 2008, compared to 54% in 1998–99. E. Pierce Blue, *Wellness Programs, the ADA, and GINA: Framing the Conflict*, 31 HOFSTRA LAB. & EMP. L.J. 367, 369–70 (2014) (noting that the use of wellness programs has grown rapidly in the United States).

promote employee health, morale, and productivity.[2] Approximately half of all U.S. employers with at least fifty employees offer a wellness program,[3] and the corporate wellness industry that services workplace wellness programs currently generates estimated annual revenues of more than $6 billion.[4] To drive employee participation in these programs, many employers are increasingly using financial incentives of varying forms,[5] including adjustments to health

2 *E.g.*, KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TR., EMPLOYER HEALTH BENEFITS 2016 ANNUAL SURVEY 212 (2016), http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey [https://perma.cc/SV8H-72AS] [hereinafter 2016 EMPLOYER HEALTH BENEFITS SURVEY]; SARAH TURK, IBISWORLD INDUSTRY REPORT OD4621: CORPORATE WELLNESS SERVICES IN THE US, JULY 2016, at 5–8 (2016), http://clients1.ibisworld.com/reports/us/industry/default.aspx?entid=4621 [https://perma.cc/3G65-WGSG] [hereinafter IBISWORLD REPORT].

3 SOEREN MATTKE ET AL., RAND CORP., WORKPLACE WELLNESS PROGRAMS STUDY: FINAL REPORT 18–19 (2013), http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf [https://perma.cc/MT76-ZPTH] [hereinafter RAND 2013 REPORT] (noting that greater percentages of large employers offer wellness programs and therefore considerably more than half (79%) of the employees working at the surveyed firms had access to wellness programs); *see also* 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 215–28 (presenting survey data on wellness programs by firm size, program type, incentive type, and other parameters).

4 IBISWORLD REPORT, *supra* note 2, at 31.

5 *See, e.g.*, Matt Lamkin, *Health Care Reform, Wellness Programs and the Erosion of Informed Consent*, 101 KY. L.J. 435, 440–41 (2013) ("[E]mployers have shown an increasing interest in programs that use financial incentives to motivate employees to change behavior. In [a 2011 survey], eighty-six percent of employers indicated they plan to implement incentive programs within the next three to five years."); Sharon Begley, *Employer Incentives for U.S. Worker Wellness Programs Set Record*, REUTERS (Mar. 26, 2015), http://www.reuters.com/article/us-usa-healthcare-wellness-idUKKBN0MM0BB20150326 [https://perma.cc/9HB3-JFKG] (citing data from a 2015 survey by Fidelity Investments and the National Business Group on Health of 121 U.S. employers); Mike Colias, *Obese Police: Firms Force Workers to Slim Down*, CRAIN'S CHICAGO BUSINESS (Feb. 26, 2007), http://www.chicagobusiness.com/article/20070226/NEWS/200023993 [https://perma.cc/EAY9-ZXUM] ("Frustrated by traditional 'wellness' programs that suffer from low participation, more

insurance contributions (e.g., premium surcharges or discounts).[6] According to one set of surveys, employers spent an average of $693 per employee on wellness incentives in 2015, more than 50% higher than the per-employee average from five years prior,[7] and 81% of employees received wellness incentives in 2015, up from 73% in 2014.[8]

Simultaneously, a complex ecosystem of statutes and regulations has been evolving as federal and state policymakers respond to the emerging forms and functions of workplace wellness programs.[9] The concurrent developments in wellness program designs and the web of regulatory standards shaping those designs have raised new questions

employers are dangling incentives—gift cards, discounts on health premiums or even cash—to persuade workers to shed pounds.").

6 *See, e.g.*, Lamkin, *supra* note 5, at 441; Madison, *supra* note 1, at 414–15.

7 Press Release, National Business Group on Health & Fidelity Investments, Companies Are Spending More on Corporate Wellness Programs but Employees Are Leaving Millions on the Table (Mar. 26, 2015), https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=252 [https://perma.cc/Y2PR-3QFZ]. This average is an increase from $594 in 2014 and $430 in 2010. Large companies with more than 20,000 employees spend the most on wellness programs, with a per-employee average of $878 in 2015; companies with between 5,000 and 20,000 employees spent an average of $661 in 2015. *Id.*

8 Press Release, National Business Group on Health & Fidelity Investments, Companies Expand Wellness Programs to Focus on Improving Employees' Emotional and Financial Well-Being (Apr. 1, 2016), https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=276 [https://perma.cc/FZN3-55AZ] ("The percent of employees receiving incentives steadily increased as employers expand well-being programs to appeal to additional elements of overall well-being, as well as provide employees with more ways to earn incentives.").

9 *See generally* KAREN POLLITZ & MATTHEW RAE, KAISER FAMILY FOUN., ISSUE BRIEF: WORKPLACE WELLNESS PROGRAMS CHARACTERISTICS AND REQUIREMENTS 1–5 (2016), http://files.kff.org/attachment/Issue-Brief-Workplace-Wellness-Programs-Characteristics-and-Requirements [https://perma.cc/W68Z-777R] (summarizing the main federal law provisions that directly address wellness programs); Madison, *supra* note 1, at 416–33 (discussing the regulatory regimes affecting wellness programs and their underlying policy objectives).

about employee privacy and dignity, protections against discrimination, employer control over health and behavior, and the proper balancing of the inherent goals of wellness programs within the patchwork of applicable laws. In particular, concerns about the applicability and compatibility of regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Patient Protection and Affordable Care Act ("ACA"), and the Americans with Disabilities Act ("ADA") have recently prompted the Equal Employment Opportunity Commission ("EEOC") to engage in rulemaking in order to harmonize its position on the permissibility of wellness incentives under the ADA with the incentive structures authorized by HIPAA-ACA regulations.[10] Tucked into the EEOC's new rules was a rebuttal to the inordinate role that one particular ADA provision has played in recent suits challenging employers' use of wellness incentives—the "most controversial"[11] § 12201(c), the ADA's "insurance safe harbor."[12]

A. Forms and Functions of Wellness Programs

The term "wellness program" broadly encompasses numerous types of services and activities that combine in multiple ways to characterize employer-sponsored wellness programs; these offerings include health risk assessments, biometric screenings, disease management programs, weight loss programs, gym membership discounts, smoking cessation programs, nutrition classes, and web-based resources for healthy living.[13] In view of the differing

10 *See* discussion *infra* Section II.B.3.

11 Katarina E. Klenner, *Competing Wellness Rules Pose Compliance Challenges*, BLOOMBERG BNA (Jul. 19, 2016), https://www.bna.com/competing-wellness-rules-n73014445179/ [https://perma.cc/6AYL-U7UV].

12 *See* discussion *infra* Section II.B.4.

13 *See, e.g.*, KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TR., EMPLOYER HEALTH BENEFITS 2015 ANNUAL SURVEY 196–98 (2015), http://files.kff.org/attachment/report-2015-employer-health-benefits-survey [https://perma.cc/HGS3-XHGF] [hereinafter 2015 EMPLOYER HEALTH

characteristics of these components, and their differing attendant legal implications, it is useful to define them for conceptual clarity. In particular, it is helpful to distinguish health screening programs, specifically health risk assessments and biometric screenings, which sometimes may be the sole components of a "wellness program," from other types of wellness offerings, such as exercise programs and health education classes. The following exercise in categorization will enable a sharper analysis of the conflicted legal treatment of "wellness programs" in recent case law, regulations, and proposed legislation.

Health risk assessments ("HRAs") are medical questionnaires designed to identify an employee's health risks, generally by asking questions about medical history, health status, and lifestyle.[14] The 2016 Employer Health Benefits Survey by the Kaiser Family Foundation ("KFF") and Health Research & Educational Trust ("HRET") found that 59% of large employers (firms with 200 or more employees) that offer health benefits to employees also offer employees an opportunity to complete an HRA;[15] these firms collectively employ more than 24 million covered workers.[16] Among these firms, around half provide incentives to employees who complete an HRA, and approximately three in ten provide those incentives in the form of lower premium

BENEFITS SURVEY]; *see also* RAND 2013 REPORT, *supra* note 3, at xiii ("A broad range of benefits are offered under the label 'workplace wellness,' from multi-component programs to single interventions, and benefits can be offered by employers directly, through a vendor, group health plans, or a combination of both."); *id.* at 21 ("A formal and universally accepted definition for workplace wellness programs has yet to emerge, and the range of benefits offered under this label is broad.").

14 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 212; *see also* RAND 2013 REPORT, *supra* note 3, at 21.

15 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 212; *see also* RAND 2013 REPORT, *supra* note 3, at 21 (reporting that survey results suggest approximately 65% of employers with wellness programs use HRAs).

16 POLLITZ & RAE, *supra* note 9, at 6.

contributions or reduced healthcare cost sharing.[17] While the 2015 Employer Health Benefits Survey by KFF and HRET found that approximately half of employees who are asked to complete an HRA actually do so,[18] notably, 5% of large firms surveyed in 2015 by KFF and HRET reported that they required employees to complete an HRA in order to enroll in an employer-sponsored health plan.[19]

Many wellness programs also incorporate biometric screenings in the form of in-person medical examinations and blood tests that measure risk factors such as body weight, blood pressure, cholesterol, stress, and nutrition.[20] The 2016 Employer Health Benefits Survey reported that, similar to the proportion of employers offering HRAs, 53% of large firms offered employees the opportunity to complete biometric screening;[21] of these firms, more than half provide

17 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 212–13 (reporting that "[a]mong large firms that have a health risk assessment, 54% offer an incentive to employees to complete the assessment" and "[a]mong large firms offering incentives for employees to complete a health risk assessment, 51% lower premium contributions or reduce cost sharing").

18 2015 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 13, at 197. The 2016 Employer Health Benefits Survey found that a slightly smaller percentage (41%) of employees completed HRAs offered by employers. 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 213. Additionally, "[t]here is considerable variation in the percentage of workers who complete the assessment. Nineteen percent of large firms providing employees the opportunity to complete a health risk assessment report that more than 75% of their employees complete the assessment, while 41% report no more than 25% of employees complete the assessment." *Id.*

19 2015 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 13, at 197. A directly comparable figure does not appear in the 2016 Employer Health Benefits Survey. *See* 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 218 exhibit 12.5 (presenting a bar chart conveying percentages of firms offering different types of incentives to employees to encourage completion of HRAs).

20 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 212–13; *see also* RAND 2013 REPORT, *supra* note 3, at 21.

21 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 213; *see also* RAND 2013 REPORT, *supra* note 3, at 21 (reporting that survey results

incentives to employees who complete a screening, and approximately three in ten provide those incentives in the form of lower premium contributions or reduced healthcare cost sharing.[22] Notably, 14% of large firms with biometric screening programs reward or penalize employees for reaching specified biometric outcomes, such as achieving a target body mass index.[23] Additionally, 7% of large firms surveyed in 2015 by KFF and HRET reported that they required employees to complete a biometric screening in order to enroll in an employer-sponsored health plan.[24]

Employers and insurers often use the health information generated through HRAs and biometric screenings to target wellness offerings to employees based on their specific risk conditions.[25] These offerings include health promotion programs such as exercise programs, health education classes, stress management counseling, and smoking

suggest approximately 49% of employers with wellness programs conduct biometric screenings).

22 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 213 (reporting that "[a]mong large firms with biometric screening programs, 59% offer an incentive for employees to complete the screening" and "[a]mong large firms with an incentive for employees to complete biometric screening, 52% lower premium contributions or reduce cost sharing").

23 *Id.* "There is considerable variation in the size of the incentives that employers offer for meeting biometric outcomes. Among large firms offering a reward or penalty for meeting biometric outcomes, the maximum reward is valued at $150 dollars or less for 10% percent of firms and $1,000 or more for 21% of firms." *Id.*

24 2015 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 13, at 197. The 2016 Employer Health Benefits Survey did not report a directly comparable figure. *See* 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 222 exhibit 12.11 (presenting a bar chart conveying percentages of firms offering different types of incentives to employees to encourage completion of biometric screenings).

25 *E.g.*, 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 212; RAND 2013 REPORT, *supra* note 3, at xv ("The RAND Employer Survey data suggest that 80 percent of employers with a wellness program screen their employees for health risks, and our case study results show that employers use results for program planning and evaluation and for directing employees to preventive interventions that address their health risks.").

cessation programs; a majority of large firms offer such programs.[26] This Note refers to these programs collectively as "wellness management programs."[27] According to the 2016 Employer Health Benefits Survey, 83% of large firms offering health benefits also offer some form of wellness management program to encourage employees to make lifestyle or behavior changes, and 42% of these large firms attach financial incentives to these programs.[28] Up to 40% of large firms offering health screening programs require employees to complete the health screening activities (HRAs and/or biometric screenings) to be eligible for wellness management program incentives.[29] In addition, once an employer has screened and identified an employee with health risks, the employer may require that employee to complete a wellness management program or face a financial penalty;[30] the 2014 Employee Health Benefits Survey

[26] *E.g.*, 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 213 (noting that "[t]hese programs may be offered directly by the firm, an insurer, or a third-party contractor").

[27] The categories described above are drawn from the Employer Health Benefits Surveys by KFF and HRET. *See, e.g.*, 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 212–13 (discussing separately data for HRAs, biometric screening, and "wellness and health promotion programs"). Other helpful ways of categorizing wellness program components are possible. *See* RAND 2013 REPORT, *supra* note 3, at 21 (distinguishing between screening activities (which include HRAs and biometric screenings), preventive interventions that address manifest health risks (such as weight-reduction counseling), and health promotion activities that further healthy lifestyles (such as healthy cafeteria options)).

[28] 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 213–14. Approximately 46% of small firms offering wellness benefits offer some form of wellness management program. *Id.*

[29] *Id.* at 213. Specifically, 44% of large firms offering HRAs require employees to complete an HRA to be eligible for incentives under wellness management programs, and 32% of large firms offering biometric screenings require employees to complete a screening to be eligible for wellness management program incentives. *Id.*

[30] *See, e.g.*, L.V. Anderson, *Workplace Wellness Programs Are a Sham*, Slate (Sept. 1, 2016), http://www.slate.com/articles/health_and_science/the_ladder/2016/09/workplace_wellness_programs_are_a_sham.html

reported that 7% of large firms asking employees to complete HRAs had such penalties in place.[31]

In implementing these various types of services and wellness-based incentives, companies have also begun to integrate new technologies, such as wearable devices and mobile applications that track employee health and behavior.[32] The use of wireless biometric sensor devices has the potential to expand the reach of wellness programs by enabling remote health monitoring, with benefits accruing to employees who might desire to keep track of chronic conditions like diabetes or high blood pressure.[33] Such devices, however, could also enable employers to remotely monitor employee health and behaviors, and some employees may find this seriously troubling, especially if combined with wellness program incentives that affect health insurance premiums and cost-sharing provisions.[34]

As evidence of variable participation rates suggests,[35] not all employees have embraced the potential opportunities presented by workplace wellness programs. In a national survey conducted by the Employee Benefits Research Institute, 33% of employees cited the concern that employers would learn their personal health information as a reason

[https://perma.cc/J5DF-X5KG] (describing a personal biometric screening experience and explaining that, because she had "passed" the biometric screening, she "wouldn't have to take a multi-week online health-improvement course to avoid paying an extra $600 on [her] health insurance next year").

31 KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS 2014 ANNUAL SURVEY 206 (2014), http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report [https://perma.cc/59A3-2FFS].

32 *See, e.g.*, Scott R. Peppet, *Regulating the Internet of Things: First Steps Toward Managing Discrimination, Privacy, Security, and Consent*, 93 TEX. L. REV. 85, 118–19 (2014).

33 Patrick J. Skerrett, *The Potential of Remote Health Monitoring at Work*, HARV. BUS. REV. 6 (Dec. 9, 2009), https://hbr.org/2009/12/the-potential-of-remote-health [https://perma.cc/A2MD-AZT2].

34 *See* Matt Lamkin, *Health Care Reform, Wellness Programs and the Erosion of Informed Consent*, 101 KY. L.J. 435, 461–62 (2013).

35 *See* RAND 2013 REPORT, *supra* note 3, at 36–42.

they declined to participate in wellness programs.[36] Such concern may be well founded since wellness programs collect an enormous amount of personal health data from employees through online forms, company surveys, wearable devices, lab tests, and other features.[37] Additionally, many wellness programs routinely obtain passive consent from program participants allowing this information to be shared with business partners and even to be used for marketing purposes.[38] To complicate matters further, privacy laws that apply to doctors, hospitals, and employers often do not apply to wellness contractors,[39] and biometric data from wearable devices are not clearly protected by the current body of data security law.[40]

Financial incentives, of course, also influence employee participation rates, though a survey by the Employee

36 PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., FINDINGS FROM THE 2013 EBRI/GREENWALD & ASSOCIATES CONSUMER ENGAGEMENT IN HEALTH CARE SURVEY 17 (2013), www.ebri.org/pdf/briefspdf/EBRI_IB_012-13.No393.CEHCS.pdf [https://perma.cc/9GFH-G9GQ]. Nearly 70% of survey respondents stated that they did not participate in wellness programs because they could make changes on their own; 56% of survey respondent reported that they did not have enough time to participate. *Id.* at 12.

37 *E.g.*, Jay Hancock, *Workplace Wellness Programs Put Employee Privacy at Risk*, CNN (Oct. 2, 2015), http://www.cnn.com/2015/09/28/health/workplace-wellness-privacy-risk-exclusive/index.html [https://perma.cc/RG2U-64GN].

38 POLLITZ & RAE, *supra* note 9, at 5. Many wellness programs require employees to sign up on a vendor's website, where participants must agree to the vendor's privacy policy and terms of service. Tara Siegel Bernard, *The Sticks and Carrots of Employee Wellness Programs*, N.Y. TIMES (Oct. 30, 2015), www.nytimes.com/2015/10/31/your-money/the-sticks-and-carrots-of-employee-wellness-programs.html?_r=0 [https://perma.cc/W25Z-ARFV].

39 *E.g.*, Hancock, *supra* note 37.

40 *E.g.*, Bernard, *supra* note 38; *see also* Peppet, *supra* note 32, at 87–97, 129–39 (discussing privacy and security issued raised by "Internet of Things" devices, such as health and fitness sensors). Additionally, a technical security problem lies in the fact that de-identified data can be re-identified and used for marketing, potential credit screening, and other purposes. Hancock, *supra* note 37; Peppet, *supra* note 32, at 133–35.

Benefits Research Institute reports that more employees cited health concerns and convenience as reasons for participating in wellness programs (70–77%) than cited financial incentives (50–58%).[41] How exactly do financial incentives impact participation rates? A RAND Corporation report found that employers with reward-only incentive plans have higher median participation rates (40%) than employers that do not use incentives (20%), but employers that used penalty-only incentives or mixed incentives had the highest participation rates (73%).[42] Notably, the report also found that wellness program configuration (whether employers offered comprehensive or limited services) was independently associated with higher participation rates, and that participation rates for comprehensive programs (which combine screening, intervention, and prevention policies) were less sensitive to incentive schemes.[43]

The proliferation of wellness program services, configurations, and incentives has created a diverse array of options for employers and employees alike. At the same time, the evolution of workplace wellness programs has also created opportunities and challenges for lawmakers aiming to influence the health and healthcare-related decisions of employers and employees. Given that employer-sponsored insurance covers more than half of the non-elderly population, approximately 150 million people in total,[44] and given that large firms account for more than half of U.S. employment,[45] the increasing use of wellness programs and of financial incentives linked to health insurance has the

41 FRONSTIN, *supra* note 36, at 17.

42 SOEREN MATTKE ET AL., RAND CORP., WORKPLACE WELLNESS PROGRAMS: SERVICES OFFERED, PARTICIPATION, AND INCENTIVES 28 (2014), http://www.dol.gov/ebsa/pdf/WellnessStudyFinal.pdf [https://perma.cc/T4QJ-ZPUZ]. The research report was sponsored by the Employee Benefits Security Administration of the U.S. Department of Labor. *Id.* at iii.

43 *Id.* at 27–28; *see also* POLLITZ & RAE, *supra* note 9 (summarizing research on the efficacy of workplace wellness programs).

44 2016 EMPLOYER HEALTH BENEFITS SURVEY, *supra* note 2, at 1.

45 Madison, *supra* note 1, at 412–13.

potential to profoundly impact a large number of American workers.[46] In this context, laws that promote and restrict wellness programs have meaningful ramifications, not only for the business plans of employers, but also in the lives of employees and their families. The thoughtful navigation of existing laws, as well as the mindful forging of new laws, is therefore of critical importance to employees, employers, and lawmakers alike.

B. A Shifting Legal Landscape

Several federal laws supply regulatory frameworks that govern the use and design of wellness programs within the context of broader protections against health-related discrimination in the workplace.[47] Regulations under HIPAA, the ACA, and the ADA together create a system of rules prohibiting health status-based discrimination in health insurance and disability-based discrimination in employment. Provisions within these laws, however, also reflect policy decisions to promote workplace wellness programs and, specifically, the use of financial incentives to encourage employees to participate in their employers' wellness initiatives. Regulators have had to face the task of reconciling the tensions between incentives tied to employees' adherence to wellness programs and commitments to preventing health-based discrimination. Complicating this endeavor, the system of legal rules governing wellness programs generally, and wellness incentives specifically, has been shifting, and doubtlessly will continue to shift, in response to new statutes, regulations, and case law; future legislation, whether specifically directed at wellness programs—such as the proposed "Preserving Employee Wellness Programs Act" (H.R. 1313)[48]—or more

46 *Id.*

47 *See generally, e.g.*, POLLITZ & RAE, *supra* note 9, at 1–5 (providing an overview of federal standards for wellness programs).

48 Preserving Employee Wellness Programs Act, H.R. 1313, 115th Cong. (2017); *see infra* notes 97–98 and accompanying text.

broadly aimed at reforming healthcare, may yet reshape the legal landscape as well.

After providing a brief review of the main statutes that address workplace wellness programs, this Section provides essential background on the relevant provisions of the ADA, how the EEOC has interpreted those provisions, and the influence of HIPAA-ACA regulations on the EEOC's regulatory approach. This Section then introduces issues arising from recent cases applying the ADA's "insurance safe harbor," in conjunction with its restrictions on disability-related inquiries and medical examinations, to the health screening components of workplace wellness programs.

1. Overview of Federal Laws

HIPAA, which was enacted on August 21, 1996, added sections to the Internal Revenue Code of 1986, the Employee Retirement Income Act of 1974, and the Public Health Service Act to prohibit discrimination based on a health factor by group health plans and group health insurance issuers.[49] These nondiscrimination provisions included an exception for wellness program incentives,[50] however, and

[49] *See generally, e.g.*, Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,014 (Dec. 13, 2006) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 146) (providing background on HIPAA's nondiscrimination provisions and the development of final rules implementing those provisions). Health factors include (1) health status, (2) medical condition, including both physical and mental illnesses, (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability, and (8) disability. 29 C.F.R. § 2590.702 (2016).

[50] *See* 29 U.S.C. § 1182 (2012). HIPAA's nondiscrimination provisions do not "prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention." *Id.*; *see also* Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. at 75,017–19 (discussing the statutory provision and development of regulations thereunder).

HIPAA's final regulations on wellness programs, issued in 2006, established that, for wellness programs meeting certain nondiscrimination requirements, incentives could reach up to 20% of the total cost of coverage under a group health plan.[51] The ACA, which was enacted on March 23, 2010, increased the maximum permissible incentive size to 30% of the cost of coverage.[52]

Title I of the ADA prohibits employment discrimination based on disability and restricts employers from asking for medical information from employees.[53] The ADA contains some exceptions to these general rules, however, and allows medical inquiries and examinations that are conducted as part of a voluntary wellness program.[54] Similarly, Title II of the Genetic Information Nondiscrimination Act ("GINA") prohibits employment discrimination based on genetic information and restricts employers from asking about an individual's genetic information; GINA also provides an exception that applies when an employee voluntarily accepts

51 Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. at 75,017–19.

52 42 U.S.C. § 300gg-4(j)(3)(A) (2012). The ACA also authorized regulators to further increase the maximum incentive size to as much as 50% of the cost of coverage. *Id.* (providing that the Secretaries of Labor, Health and Human Services, and the Treasury "may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate"). Final regulations under this provision increased the maximum reward to 50% of the cost of coverage for wellness programs designed to prevent or reduce tobacco use. Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158, 33,166–67 (June 3, 2013) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146 and 147).

53 42 U.S.C. §§ 12112(a), (d)(4)(A) (2012).

54 42 U.S.C. § 12112(d)(4)(B) (2012); *see also* Madison, *supra* note 1, at 437 (noting that "[i]n 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'").

health or genetic services that are offered as part of an employer-sponsored wellness program.[55]

2. The ADA's Voluntariness Exception

Title I of the ADA generally prohibits discrimination "against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."[56] The ADA also provides that this prohibition against discrimination "shall include medical examinations and inquiries."[57] In addition to provisions applicable to pre-employment practices and employee entrance examinations,[58] the ADA provides:

> 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-related and consistent with business necessity.[59]

The EEOC defines "disability-related inquiry" broadly as a "question (or series of questions) that is likely to elicit information about a disability."[60] The EEOC defines a "medical examination" as "a procedure or test that seeks

55 42 U.S.C. § 2000ff–1 (2012).

56 42 U.S.C. § 12112(a). The term "qualified individual" means "an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." 42 U.S.C. § 12111(8) (2012).

57 42 U.S.C. § 12112(d)(1) (2012).

58 42 U.S.C. §§ 12112(d)(2)–(3) (2012).

59 42 U.S.C. § 12112(d)(4)(A) (2012).

60 *Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA)*, U.S. EQUAL EMP'T OPPORTUNITY COMM'N (July 27, 2000), https://www.eeoc.gov/policy/docs/guidance-inquiries.html [http://perma.cc/E7V7-LW6N] [hereinafter *EEOC Enforcement Guidance*].

information about an individual's physical or mental impairments or health."[61] Examples of medical examinations include blood pressure screening, cholesterol testing, range-of-motion tests, pulmonary function tests, and vision tests.[62] Importantly, the provision applies to all employees, not only those with disabilities.[63] Generally speaking, if a wellness program does not require participating employees to answer disability-related questions or undergo medical examinations, then the ADA "simply requires that an employer make any reasonable accommodation necessary to enable an employee with a disability to participate."[64]

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61 *Id.*

62 *Id.* Procedures and tests that are not considered "medical examinations" under the ADA include drug tests, physical agility tests (which measure an employee's ability to perform job tasks), physical fitness tests (which measure an employee's performance of physical tasks but do not measure physiological responses such as heart rate or blood pressure), and psychological personality tests. *Id.*

63 *Id.* The enforcement guidance explains:

> This statutory language makes clear that the ADA's restrictions on inquiries and examinations apply to all employees, not just those with disabilities. Unlike other provisions of the ADA which are limited to qualified individuals with disabilities, the use of the term "employee" in this provision reflects Congress's intent to cover a broader class . . . Requiring an individual to show that s/he is a person with a disability in order to challenge a disability-related inquiry or medical examination would defeat this purpose. *Any* employee, therefore, has a right to challenge a disability-related inquiry or medical examination that is not job-related and consistent with business necessity.

Id. Additionally, a medical examination or inquiry may be "job-related and consistent with business necessity" when an employer "has a reasonable belief, based on objective evidence, that: (1) an employee's ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition." *Id.*

64 *Written Testimony of Christopher Kuczynski, Acting Associate Legal Counsel*, U.S. EQUAL EMP'T OPPORTUNITY COMM'N (May 8, 2013), http://www.eeoc.gov/eeoc/meetings/5-8-13/kuczynski.cfm [https://perma.cc/KR5Z-NS9J] [hereinafter *Kuczynski Testimony*].

For wellness programs that involve medical examinations or inquiries, as many do by consisting of health screening programs that utilize HRAs and biometric screenings, § 12112(d)(4)(B) provides an exception that allows employers to "conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."[65] In 2000, the EEOC issued enforcement guidance taking the position that a wellness program is "voluntary" under the ADA "as long as an employer neither requires participation nor penalizes employees who do not participate."[66] However, the enforcement guidance did not offer further direction on the permissibility of wellness incentives, which were not as common at the time the guidance was issued as presently.[67]

In 2014, the EEOC brought enforcement actions against three employers that had imposed heavy penalties, including the full denial of health insurance coverage, on employees who did not complete the health screening components of their "wellness programs" (e.g., who did not undergo biometric screenings).[68] In response to this litigation,

65 42 U.S.C. § 12112(d)(4)(B) (2012). This exception is sometimes referred to as the "voluntariness exception." *See, e.g.*, Madison, *supra* note 1, at 432. Additionally, "[a] covered entity may make inquiries into the ability of an employee to perform job-related functions." § 12112(d)(4)(B).

66 *EEOC Enforcement Guidance*, *supra* note 60; *see also supra* note 54.

67 *See Kuczynski Testimony*, *supra* note 64. In 2009, legal counsel for the EEOC issued a letter—in response to an inquiry by a county as to whether it would be permissible to condition participation in a health plan on completion of an HRA—that suggested financial incentives would be permissible if they remained under 20% of the cost of health insurance coverage, the limit provided by the 2006 HIPAA regulations. This portion of the letter was rescinded two months later, however. *See* Madison, *supra* note 1, at 426–28 (reviewing the history of EEOC enforcement guidance on the meaning of "voluntary").

68 *See* EEOC v. Honeywell Int'l, Inc., No. 14-4517, 2014 WL 5795481 (D. Minn. Nov. 6, 2014); EEOC v. Flambeau, Inc., 131 F. Supp. 3d 849 (W.D. Wis. 2015), *aff'd*, 846 F.3d 941 (7th Cir. 2017); EEOC v. Orion Energy Sys., Inc., No. 14-cv-1019, 2016 WL 5107019, at *1 (E.D. Wis. Sept. 19, 2016).

employers and groups such as the Business Roundtable argued that the ADA should not be interpreted to restrict the use of financial incentives authorized by HIPAA and the ACA.[69] On March 2, 2015, Rep. John Kline introduced a bill into Congress, the "Preserving Employee Wellness Programs Act" (H.R. 1189), that declared that wellness programs complying with the ACA's requirements for offering wellness incentives would not violate the ADA or GINA.[70] Then, in April 2015, the EEOC issued a proposed rule seeking to resolve questions about the permissibility under the ADA of wellness programs meeting the standards of HIPAA-ACA regulations.

3. Wellness Incentives and Voluntariness

On May 17, 2016, the EEOC issued a final rule to provide guidance on the application of the ADA's "voluntary" wellness programs provision, reflecting an effort by the agency to harmonize the standards for allowable wellness incentives under the ADA and HIPAA-ACA regulations.[71] In its discussion of the interaction of the ADA's and HIPAA's nondiscrimination provisions in its Notice of Proposed Rulemaking, the EEOC explained that, while a reading of "voluntary" in isolation could plausibly limit wellness incentives to *de minimis* rewards or penalties, such an interpretation would make impermissible under the ADA many wellness program incentives expressly permitted by

69 *See, e.g.*, *BRT Letter in Response to EEOC Actions Targeting Employer Wellness Programs*, BUS. ROUNDTABLE (Nov. 14, 2014), http://businessroundtable.org/resources/brt-letter-response-eeoc-actions-targeting-employer-wellness-programs [https://perma.cc/Z82V-VXZB]; Madison, *supra* note 1, at 429; POLLITZ & RAE, *supra* note 9, at 3.

70 Preserving Employee Wellness Programs Act, H.R. 1189, 114th Cong. (2015).

71 Regulations Under the Americans With Disabilities Act, 81 Fed. Reg. 31,126 (May 17, 2016) (to be codified at 29 C.F.R. pt. 1630).

HIPAA and the ACA.[72] While the EEOC acknowledged that compliance with HIPAA-ACA regulations is not determinative of compliance with the ADA, the agency explained that it "believes that it has a responsibility to interpret the ADA in a manner that reflects both the ADA's goal of limiting employer access to medical information and HIPAA's and the Affordable Care Act's provisions promoting wellness programs."[73]

Regulations implementing HIPAA's nondiscrimination provisions distinguish between two types of wellness programs: participatory and health-contingent.[74] Participatory wellness programs either do not provide a reward or do not condition rewards on an employee's satisfaction of a standard related to a health factor.[75] Examples include a diagnostic testing program that rewards employees for participation and does not base any part of the reward on outcomes, and a program that rewards employees for attending free health education seminars.[76] Under HIPAA, participatory wellness programs are permissible as long as they are made available to all similarly situated individuals.[77] Notably, HIPAA regulations do not limit the magnitude of incentives that employers may offer for

72 Amendments to Regulations Under the Americans With Disabilities Act, 80 Fed. Reg. 21,659, 21,662 (proposed Apr. 20, 2015) (to be codified at 29 C.F.R. pt. 1630).

73 *Id.*

74 *E.g.*, Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158, 33,158–59 (Jun. 3, 2013) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146 and 147).

75 *Id.* at 33,160–61.

76 *Id.* Other examples include: "A program that reimburses employees for all or part of the cost for membership in a fitness center [and] a program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking . . ." Amendments to Regulations Under the Americans With Disabilities Act, 80 Fed. Reg. at 21,661.

77 Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,161.

participatory wellness programs;[78] because incentives tied to participatory wellness programs are not based on health factors, they do not implicate the core of HIPAA's protections against health-based discrimination.

Health-contingent wellness programs, on the other hand, require employees to satisfy a standard related to a health factor to obtain a reward.[79] HIPAA's rules discuss two types of health-contingent programs. Activity-only health-contingent programs, such as walking, diet, and exercise programs, incentivize employees to complete an activity related to a health factor but do not require an individual to attain a specific health outcome to obtain the reward.[80] Outcome-based health-contingent programs, meanwhile, require employees to attain or maintain a specific health outcome, such as achieving certain results on biometric screenings, to obtain a reward.[81] Because these programs involve incentives that run directly against HIPAA's prohibition against health-based discrimination in group health plans, employers must abide by five specific requirements to comply with HIPAA's rules,[82] including the

78 *Id.*; *see also* David Orentlicher, *Health Care Reform and Efforts to Encourage Healthy Choices by Individuals*, 92 N.C.L. REV. 1637, 1649 (2014) ("To encourage enrollment in employer wellness programs, the ACA extends provisions in [HIPAA] that allow employers to promote program participation with financial incentives. For incentives that are tied simply to participation, there are no limits on the magnitude of the incentives. Employers can reward their employees with $50, $500, or $5,000 if they sign up for workplace wellness programs.").

79 Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,161.

80 *Id.*

81 *Id.*

82 *Id.* at 33,162–66. The five requirements may be summarized as follows:

> Generally, health-contingent wellness programs must be available to all similarly situated individuals and must: (1) Give eligible individuals an opportunity to qualify for a reward at least once per year; (2) limit the size of the reward to no more than 30 percent of the total cost of coverage (or, 50 percent to the extent that the wellness

requirement that the reward for a health-contingent wellness program must not exceed 30% of the total cost of employee-only coverage under a group health plan or 50% for programs designed to prevent or reduce tobacco use.[83]

The EEOC's new regulations generally conform the agency's position on wellness incentives to the standards contained in the HIPAA-ACA regulations; the final regulations provide that an employer may offer incentives up to the same maximum of 30% of the total cost of employee-only coverage to promote wellness programs.[84] They specify that an employee health program is "voluntary" as long as the employer (1) does not require participation; (2) does not deny coverage under any of its group health plans for nonparticipation or limit the extent of benefits for employees who do not participate beyond the maximum allowable incentives specified in 29 C.F.R. § 1630.14(d)(3); and (3) provides its employees with a notice describing the type of medical information that will be obtained, specific purposes for which the medical information will be used, and restrictions on the disclosure of the employee's medical

> program is designed to prevent or reduce tobacco use): (3) provide a reasonable alternative standard (or waiver) to qualify for a reward; (4) be reasonably designed to promote health or prevent disease and not be overly burdensome; and, (5) disclose the availability of a reasonable alternative standard to qualify for the reward in plan materials that provide details regarding the wellness program.

Regulations Under the Americans With Disabilities Act, 31,126, 31,128 (May 17, 2016).

83 Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33,159, 33,161–62.

84 29 C.F.R. § 1630.14(d)(3) (2016); *see also* Regulations Under the Americans With Disabilities Act, 81 Fed. Reg. at 31,133 ("To give meaning to the ADA's requirement that an employee's participation in a wellness program must be voluntary, the incentives for participation cannot be so substantial as to be coercive. . . . Nonetheless, although substantial, the Commission concludes that, given current insurance rates, offering an incentive of up to 30 percent of the total cost of self-only coverage does not, without more, render a wellness program coercive.").

information.[85] Additionally, a wellness program must be reasonably designed to promote health or prevent disease to qualify as an "employee health program."[86]

Notably, however, the final rules extend the 30% limit based on the HIPAA-ACA framework to cover participatory wellness programs that ask employees to respond to disability-related inquires or undergo medical examinations.[87] The difference between the proposed ADA rules and HIPAA rules reflects the distinct focuses of the relevant provisions within the two laws; whereas the HIPAA provisions focus on restricting wellness incentives to restrict health-based discrimination in insurance premiums, benefits, or eligibility based on a health factor, the relevant ADA provisions aim to ensure that medical examinations and inquiries are voluntary to restrict employers from obtaining medical information from employees and thereby prevent disability-related employment discrimination.[88]

4. The ADA's Insurance Safe Harbor

Much attention has been paid by policymakers, employers, employees, and academics to questions surrounding the proper magnitude of wellness incentives. Is 30% of the total cost of coverage—which includes the amounts the employer *and* employee pay—too much,

[85] § 1630.14(d)(2). Additionally, an employer may "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." § 1630.14(d)(2)(iii).

[86] § 1630.14(d)(1).

[87] § 1630.14(d)(3).

[88] *See, e.g.*, Regulations Under the Americans with Disabilities Act, 81 Fed. Reg. at 31,129 ("[The EEOC] reaffirms its conclusion that allowing certain incentives related to wellness programs, while limiting them to prevent economic coercion that could render provision of medical information involuntary, is the best way to effectuate the purposes of the wellness program provisions of both laws.").

unaffordable, coercive, arbitrary?[89] Yet, recent cases considering whether the health screening components of wellness programs have violated the prohibition on disability-related inquiries and medical examinations contained in § 12112(d)(4)(A) have paid little, if any, attention to the meaning of "voluntary" in § 12112(d)(4)(B).[90] Instead, the spotlight has fallen on 42 U.S.C. § 12201(c), the ADA's "insurance safe harbor," which provides:

> Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict—
>
> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
> (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
> (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

89 *See generally, e.g.*, Regulations Under the Americans with Disabilities Act, 81 Fed. Reg. at 31,132–36 (discussing public comments submitted to the EEOC regarding wellness incentives); Madison, *supra* note 1, at 433–55 (discussing how the goals underlying the ACA and ADA may support divergent approaches to setting limits on wellness incentives).

90 *See infra* Part III.

> Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III.[91]

In 2012, the reasoning of a court in Florida[92] generated an analytical framework that has muddled the discussion over the meaning of § 12201(c) and its application to "wellness programs" in the subsequent case law, the EEOC's new regulation, and recently proposed legislation. In response to the decisions in *Seff v. Broward County*[93] and *EEOC v. Flambeau, Inc.*,[94] which determined that certain wellness programs, and by extension, the financial incentives tied to these programs, were "terms" of a benefit plan "based on underwriting risks, classifying risks, or administering such risks" and therefore protected by the insurance safe harbor, the EEOC added a provision in its final rules that explicitly states: "The 'safe harbor' provisions . . . applicable to health insurance, life insurance, and other benefit plans do not apply to wellness programs, even if such plans are part of a covered entity's health plan."[95]

In its responses to public comments, the EEOC noted that, in addition to employer associations and industry groups that had argued in favor of applying the safe harbor to wellness programs, "[s]everal members of Congress asserted that the EEOC was inappropriately seeking to rewrite the statute and vacate court decisions through regulation."[96] A bill introduced into Congress by Rep. Virginia Foxx in March, which has already generated sharp criticism based on concerns about its removing protections

91 42 U.S.C. § 12201(c) (2012).

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

93 *Id.*

94 131 F. Supp. 3d 849, 851 (W.D. Wis. 2015), *aff'd*, 846 F.3d 941 (7th Cir. 2017).

95 29 C.F.R. § 1630.14(d)(6) (2016).

96 Regulations Under the Americans with Disabilities Act, 81 Fed. Reg. at 31,130.

for employees' genetic information,[97] contains a blunt retort to the EEOC's position, simply declaring: "Notwithstanding any other provision of law, section 501(c)(2) of the Americans with Disabilities Act of 1990 (42 U.S.C. 12201(c)(2)) shall apply to workplace wellness programs or programs of health promotion or disease prevention offered by an employer in conjunction with an employer-sponsored health plan."[98]

III. ISSUES IN APPLICATIONS OF THE ADA TO WELLNESS PROGRAMS

Three provisions in the ADA, § 12112(d)(4)(A), § 12112(d)(4)(B), and § 12201(c), have shaped recent court decisions interpreting the statute's application to two common components of workplace wellness programs, HRAs and biometric screenings, and the incentives that companies have adopted to increase employee participation in such health screening programs. While the EEOC's recently issued regulation on wellness incentives directly responds to how courts have interpreted and applied the ADA's insurance safe harbor to health screening programs, gaps remain in the developing doctrine governing the permissibility of different forms of health screening requirements.

This Part of the Note will examine inconsistencies in the application of the three ADA provisions in recent cases and compare arguments by employers, plaintiffs, and the EEOC on how to treat wellness programs under the ADA. This Part

97 *See, e.g.*, Reed Abelson, *How Healthy Are You? G.O.P. Bill Would Help Employers Find Out*, N.Y. TIMES (Mar. 10, 2017), https://www.nytimes.com/2017/03/10/health/workplace-wellness-programs-health-genetic-data.html [https://perma.cc/RMH8-USNH]; Lena H. Sun, *Employees Who Decline Genetic Testing Could Face Penalties Under Proposed Bill*, WASH. POST (Mar. 11, 2017), https://www.washingtonpost.com/news/to-your-health/wp/2017/03/11/employees-who-decline-genetic-testing-could-face-penalities-under-proposed-bill/?utm_term=.c0b9d36b9141 [https://perma.cc/A268-BJNJ].

98 Preserving Employee Wellness Programs Act, H.R. 1313, 115th Cong. § 3(a)(1)(C) (2017).

will begin with a discussion of the struggle of courts and the EEOC to properly situate the safe harbor provision within arguments about the permissibility of wellness incentives. The Note will then explore how the EEOC's new regulations, specifically 29 C.F.R. § 1630.14(d)(6), and accompanying guidance do not completely resolve how the ADA governs health screening requirements in light of remaining questions about the precise application of the prohibition on disability-related inquires and medical examinations to health screening programs.

A. Purpose of the Insurance Safe Harbor

Recognizing that without clarification the ADA "could arguably find violative of its provisions any action taken by an insurer or employer which treats disabled persons differently under an insurance or benefit plan because they represent an increased hazard of death or illness,"[99] Congress provided § 12201(c), a construction clause "explaining that the ADA does not disrupt the current nature of insurance underwriting when based on valid classification of risk."[100] In short, the ADA's "insurance safe harbor" makes clear that insurers and employers may treat disabled individuals differently under an employee benefit plan if justified by "legitimate underwriting or classification of risks,"[101] but decisions concerning the insurance of disabled individuals that are not "based on bona fide risk

99 H.R. REP. NO. 101-485, pt. 2, at 138 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 421.

100 H.R. REP. NO. 101-485, pt. 2, at 24 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 306; *see also id.* at 136 ("As indicated earlier in this report, the main purposes of this legislation include prohibiting discrimination in employment, public services, and places of public accommodation. The Committee does not intend that any provisions of this legislation should affect the way the insurance industry does business in accordance with the State laws and regulations under which it is regulated.").

101 H.R. REP. NO. 101-485, pt. 3, at 70 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 445, 493.

classification" must still conform with the ADA's non-discrimination requirements.[102] As the EEOC noted in the preamble to its final rule, the insurance safe harbor protected some practices that are now unlawful, such as charging individuals in a group health plan higher rates based on the increased risks associated with their medical conditions.[103]

On their face, the insurance safe harbor provisions are silent with respect to disability-related inquiries or medical examinations; instead, the safe harbor simply clarifies that the ADA's prohibitions on discrimination in employment, public services, and places of public accommodation do not prevent differential treatment of disabled persons in the realm of insurance, so long as such treatment is based on sound actuarial principles. In 1998, however, the court in *Barnes v. Benham Group*,[104] a case concerning an alleged violation of § 12112(d)(4)(A)'s prohibition on disability-related inquiries, applied § 12201(c)'s exception relating to insurance activities to uphold a requirement that employees complete a medical questionnaire in order to participate in an employer's group health insurance plan.

B. *Barnes*

In *Barnes*, the defendant, an architectural and engineering design firm, sought to secure a new group health insurance plan for the thirty-four employees in its St. Paul office.[105] To that end, the defendant's employees were asked to complete application enrollment forms from three bidding group health insurance providers; these forms solicited

102 H.R. REP. NO. 101-485, pt. 2, at 138 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 421; *see also* U.S. EQUAL EMP'T OPPORTUNITY COMM'N, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (1993), 1993 WL 1497027.

103 Regulations Under the Americans with Disabilities Act, 81 Fed. Reg. 31,126, 31,130 (May 17, 2016) (to be codified at 29 C.F.R. pt. 1630).

104 22 F. Supp. 2d 1013 (D. Minn. 1998).

105 *Id.* at 1016–17.

biographical and medical information from employees, including questions about an employee's history of health conditions, to allow for an assessment of the risks of insuring the defendant's employees and calculation of a premium.[106] Employees who did not complete these forms were ineligible to participate in the group insurance plan and were asked to sign a waiver acknowledging they had declined the opportunity to apply for coverage.[107] After the plaintiff refused to provide the requested information or sign the waiver, the defendant employer terminated the plaintiff's employment, citing "insubordination," leading to the plaintiff's suit.[108] To establish a case of illegal retaliation, the plaintiff argued that he was engaged in protected activity in opposing unlawful employer conduct, i.e., the allegedly unlawful medical inquiries that were required as part of the health insurance enrollment process.[109]

The court, however, agreed with the defendant's argument that the questions were allowed by the insurance safe harbor because the questions "were asked solely for the purpose of underwriting, classifying, and administering risks in conjunction with defendant's search for a new group health plan," and the court further noted that the employer defendant had "sought to establish, sponsor, observe, or administer the terms of a bona fide benefit plan based on underwriting, classifying, or administering risks."[110] The court reasoned that the "purpose of the safe harbor provision is to permit the development and administration of benefit plans in accordance with accepted principles of risk assessment," and therefore the questions in the enrollment forms were permissible under the ADA.[111] The analysis in *Barnes* pertaining to the application of the safe harbor to health questionnaires has been accepted by employers,

106 *Id* at 1017, 1019.

107 *Id.* at 1017.

108 *Id.*

109 *Id.* at 1022.

110 *Id.* at 1020.

111 *Id.*

courts, and the EEOC alike.[112] Essentially, the court viewed the requirement that employees complete the enrollment forms, in addition to the questions themselves, as part of the insurer's process of underwriting insurance products and therefore protected by § 12201(c)(1).[113] The employer defendant had acted to facilitate this process, with the intention of establishing terms of a benefit plan based on underwriting or classification of risks, consistent with the provision in § 12201(c)(2).[114]

C. *Seff*

More than a decade later in *Seff v. Broward County*, a district court in Florida dusted off the safe harbor analysis in *Barnes* in the process of ruling against class action plaintiffs who had challenged a $20.00 bi-weekly penalty for declining to complete an HRA and biometric screening that together comprised a "wellness program" offered by Broward County.[115] Despite citing *Barnes*, the Florida court trudged through its interpretation of § 12201(c) by developing a unique two-step analysis of the safe harbor unmoored from the purpose and design of the provision.

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112 *See, e.g.*, Opening Brief of the Equal Employment Opportunity Commission as Appellant at 29, Equal EEOC v. Flambeau, 846 F.3d 941 (7th Cir. 2017) (No. 16-1402) ("In contrast, a health risk assessment asking disability-related questions for the purpose of acquiring or pricing group health insurance could fall under the safe harbor exception for insurance underwriting.") (citing *Barnes*, 22 F. Supp. 2d at 1020 and Bloch v. Rockwell Lime Co., N0. 07–478, 2007 WL 4287275, at *6 (E.D. Wis. Dec. 4, 2007)).

113 *See Barnes*, 22 F. Supp. 2d at 1020; *see also* H.R. REP. NO. 101-485, Part 3, at 70 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 445, 493 (explaining that § 12201(c)(1) clarifies that insurers may continue to sell insurance products "so long as the standards used are based on sound actuarial data" and that § 12201(c)(2) "recognizes the need for employers, and/or agents thereof, to establish and observe the terms of employee benefit plans, so long as these plans are based on underwriting or classification of risks").

114 *See Barnes*, 22 F. Supp. 2d at 1017, 1019–20.

115 Seff v. Broward Cty., 778 F. Supp. 2d 1370 (S.D. Fla. 2011).

In 2009, "saddled with an aging workforce," Broward County sought ways to address its increasing healthcare costs, including by attempting to improve the overall health of its workforce.[116] Based on the recommendation of its healthcare consultant, Broward County adopted a health screening program[117] as part of its health plan's enrollment process.[118] The health screening program consisted of two components: an HRA and a biometric screening; the HRA was an online medical questionnaire, and the biometric screening required a finger stick blood test to measure glucose and cholesterol levels.[119] The program was administered and paid for by Broward County's health insurer, and, unlike the scenario in *Barnes*, participation in the program was not required for health coverage.[120] Information obtained from the health screening program was not disclosed to Broward County, except that Broward County did receive de-identified aggregated data that it "may consider in creating future benefit plans."[121] The health screening data was also used to facilitate a disease management program.[122] In 2010, Broward County decided to incentivize participation in the program: employees who declined to complete the HRA and biometric screening incurred a $20.00 charge on each bi-weekly paycheck.[123]

Departing from the logic of *Barnes*, which would suggest an evaluation of whether the health screening program and the $20.00 bi-weekly incentive could appropriately be

116 *Id.* at 1371.

117 Referred to in the case under the broader term "wellness program." *Id.* at 1371–72.

118 *Id.*

119 *Id.*

120 *Id.* at 1372.

121 *Id.*

122 *Id.* Employees who completed the program and were identified by the insurer to have one of five disease states (asthma, hypertension, diabetes, congestive heart failure, or kidney disease) were given the opportunity to participate in a disease management coaching program and become eligible to receive medications at no additional cost. *Id.*

123 *Id.*

considered part of developing a benefit plan "in accordance with accepted principles of risk assessment,"[124] the court began its analysis by asking whether the health screening program itself was a "term" of a bona fide benefit plan.[125] The court concluded that it "views the wellness program as a term of the County's group health plan," based on the facts that (1) the insurer paid for and administered the program under its healthcare contract with the county, (2) only those enrolled in the county's health plan could participate in the wellness program, and (3) the county's benefit plan employee handout informed plan enrollees that they "will have to participate in both the Biometric Screening and online Health Risk Assessment."[126]

Next, as a second step, the court determined that the program was "based on underwriting risks, classifying risks, or administering risks."[127] After considering the "limited case law" on the meaning of this language in the safe harbor provision, the court concluded that the terms "collectively refer to the process of collecting information about the health of the insured in order to assess risks so the insurer may accurately establish premiums—in other words: the process of developing insurance plans."[128] Notably, the court cited to *Barnes*,[129] as well as to another case from 1998, *Zamora-Quezada v. HealthTexas Med. Grp. of San Antonio*.[130] In *Zamora-Quezada*, the court applied interim guidance from the EEOC to define "underwriting" as generally referring "to the application of the various risk factors or risk classes to a

124 Barnes v. Benham Grp., 22 F. Supp. 2d 1013, 1020 (D. Minn. 1998).

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

126 *Id.*

127 *Id.* at 1373–74.

128 *Id.*

129 "Indeed, '[t]he purpose of the safe harbor provision is to permit the development and administration of benefit plans in accordance with accepted principles of risk assessment.'" *Id.* (citing Barnes v. Benham Grp., 22 F.Supp.2d 1013, 1020 (D. Minn. 1998)).

130 34 F. Supp. 2d 433 (W.D. Tex. 1998).

particular individual or group for the purposes of determining whether to provide coverage."[131] And "risk classification," in the context of the safe harbor, "refers to the identification of risk factors and the groupings of those factors which pose similar risks."[132] As described thus far, the court's recitation of statements regarding the interpretation of the safe harbor in this step of its analysis does not deviate much from the statutory language, legislative history, or analysis provided in *Barnes* and *Zamora-Quezada*.

The court's application of § 12201(c) to Broward County's health screening program, however, if not fairly characterized as conclusory, journeyed away from these interpretive guidelines. After observing that the health screening program "render[ed] aggregate data to the County that it may analyze when developing future benefit plans," the court characterized the employer's "acting as an employer seeking to gather information that would be used to design future benefit plans" as "underwriting and classifying risks on a macroscopic level."[133] Further diluting the safe harbor provision, the court reasoned that the health screening program was "designed to mitigate risks," and, "[l]ike the company in *Barnes*, Broward County acted to solicit medical information from its employees with a view toward assessing risks."[134] As the EEOC observed in the preamble to its final rule, adhering to the reasoning in *Seff* would make permissible any practice by an employer with the goal of reducing insurance costs.[135] Having drawn the

131 *Id.* at 442–43.

132 *Id.*

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

134 *Id.* at 1374. "In other words, the program is based on underwriting, classifying, and administering risks because its ultimate goal is to sponsor insurance plans that maintain or lower its participant's premiums." *Id.*

135 Regulations Under the Americans With Disabilities Act, 81 Fed. Reg. 31,126, 31,131 (May 17, 2016) (to be codified at 29 C.F.R. pt. 1630). On appeal, the only issue raised was whether the district court erred in the first step of its analysis: its determination that the health screening

conclusion that the safe harbor protected Broward County's actions, the court did not address the defendant's alternative argument that the program was permissible as a voluntary wellness program.[136]

D. *Flambeau*

A few years after the decision in *Seff*, a court in Wisconsin applied a two-step analysis derived from *Seff* to rule that employers may deny health insurance coverage to employees who choose not to complete a health screening program.[137] As expressed in one news article, under the ruling in *EEOC v. Flambeau, Inc.*, employees might face a choice that essentially boils down to "take a blood test or lose your health coverage."[138]

In *Flambeau*, the EEOC contended that the defendant violated § 12112(d)(4)(A) by conditioning participation in its employee health insurance plan on the completion of an HRA

program was a "term of a bona fide benefit plan." Seff v. Broward Cty., Fla., 691 F.3d 1221, 1223 (11th Cir. 2012). The Eleventh Circuit upheld the district court's ruling because the County's insurance company "sponsored the wellness program," "the program was only available to group plan enrollees," and the County "presented the program as part of its group plan in at least two employee handouts." *Id.* at 1224. Because the district court found that the health screening program and, by apparent implication, its associated financial incentives, fell within the ADA's safe harbor provision, the Eleventh Circuit also declined to address whether the program imposed non-voluntary medical examinations or inquiries that would otherwise would have been prohibited by 42 U.S.C.A. § 12112(d)(4). *See id.* at 1221–22.

136 *Seff*, 778 F. Supp. 2d at 1372 n.3.

137 EEOC v. Flambeau, Inc., 131 F. Supp. 3d 849 (W.D. Wis. 2015). On appeal, the Seventh Circuit concluded that the EEOC's claim for injunctive relief was moot and therefore did not resolve the question of how the insurance safe harbor should be interpreted. EEOC v. Flambeau, Inc., 846 F.3d 941, 944 (7th Cir. 2017).

138 Rebecca Greenfield, *Employee Wellness Programs Not So Voluntary Anymore*, BLOOMBERG BUS. (Jan. 15, 2016), http://www.bloomberg.com/news/articles/2016-01-15/employee-wellness-programs-not-so-voluntary-anymore [https://perma.cc/4CEW-SWLX].

and a biometric screening test.[139] Despite notable similarities between the case in *Flambeau* and the case in *Barnes*, the court followed *Seff* in conducting its analysis of the insurance safe harbor.[140]

In October 2010, the defendant established a health screening program[141] for employees who wanted to enroll in its self-funded health insurance plan for the 2011 benefit year.[142] Similar to the program at issue in *Seff*, the health screening program had two components: (1) an HRA, which required participants to complete a questionnaire about their medical history, diet, mental and social health, and job satisfaction; and (2) a biometric test, which was similar to a routine physical and involved height and weight measurements, a blood pressure test, and a blood draw.[143]

Information collected through this health screening program was reported to the defendant in the aggregate and "used to identify the health risks and medical conditions common among the plan's enrollees."[144] The court found that the defendant used this information to "estimate the cost of providing insurance, set participants' premiums, evaluate the need for stop-loss insurance, adjust the co-pays for preventive exams and adjust the co-pays for certain prescription drugs."[145] As part of its wellness offerings, the defendant also sponsored other initiatives, such as weight loss competitions, to address the fact that a high percentage of its employees appeared to suffer from nutrition and weight

139 *Flambeau*, 131 F. Supp. 3d at 851.

140 *See id.* at 855–56.

141 Like the case in *Seff*, the health screening program comprised one component of a wellness program and is referred to in the case under the broader term "wellness program." *Id.* at 851.

142 *Flambeau*, 131 F. Supp. 3d at 852.

143 *Id.*

144 *Id.*

145 *Id.* The EEOC argued it did not. *See, e.g.*, Opening Brief of the Equal Employment Opportunity Commission as Appellant at 30–31, EEOC v. Flambeau, 846 F.3d 941 (7th Cir. 2016) (No. 16-1402).

management problems.[146] For the 2011 benefit year, the defendant promoted its health screening program by providing a $600 reward to employees if they completed the HRA and biometric test, but in 2012 and 2013, the defendant eliminated the $600 credit and instead offered health insurance only to employees who completed the health screening program.[147]

At this point, the facts of this case could be analogized to the facts in *Barnes*, and the court might have applied the analysis of *Barnes* to hold, for instance, that the safe harbor creates an exception to the ADA's general restrictions such that the statute does not prohibit an employer's requiring employees to complete medical questionnaires (and, in this case, biometric tests) when the requested medical information is sought for the purpose of developing a bona fide health insurance plan (in this case, a self-insured plan). Instead, the court attempted to follow the analytical steps in *Seff*.

First, the court determined that the wellness program requirement was a "term" of defendant's benefit plan because (1) employees were required to complete the wellness program before they could enroll in the plan, and "[i]t is difficult to fathom how such a condition could be anything other than a plan term," (2) defendant distributed handouts to employees informing them of the wellness program requirement, and (3) the plan's "summary plan description explained that participants would be required to enroll 'in the manner and form prescribed by [defendant].'"[148]

Second, the court concluded that the wellness program requirement was "based on underwriting risks, classifying risks, or administering such risks."[149] Following the court in *Seff*, the court in *Flambeau* observed that, based on the "limited case law," these terms refer "simply to the process of

146 *Flambeau*, 131 F. Supp. 3d at 852.

147 *Id.*

148 *Id.* at 855.

149 *Id.* at 856.

developing an insurance plan."[150] The court found that the "undisputed evidence establishes that defendant's consultants used the data gathered through the wellness program to classify plan participants' health risks and calculate defendant's projected insurance costs for the benefit year" and to provide recommendations regarding plan "premiums."[151] Additionally, the defendant used the wellness program data in reaching its decision to purchase stop-loss insurance.[152] The court reasoned that such decisions "are a fundamental part of developing and administering an insurance plan and therefore fall squarely within the scope of the safe harbor."[153]

The EEOC raised several objections to the court's *Seff*-inspired analysis,[154] but setting aside the problems with the court's application of § 12201(c) based on a questionable framework of analysis, the facts as found by the court and its reasoning within the second step of its analysis are analogous to the facts and analysis in *Barnes*. The EEOC itself has argued in litigation, for instance, that the "safe harbor applies when an employer or insurance company seeks to underwrite an insurance policy by requiring employees to answer disability-related questions so that the premium can be calculated," and when the employer is otherwise "engaging in a function of the insurance industry."[155] Therefore, the ultimate outcome of the district court's analysis in *Flambeau*, if not the pathway to it, appears aligned with the view of the safe harbor expressed in *Barnes*.

150 *Id.*

151 *Id.*

152 *Id.*

153 *Id.*

154 *See id.* at 853–55.

155 EEOC's Reply in Support of its Motion for Partial Summary Judgment at 2–3, EEOC v. Orion Energy Sys., No. 14-1019, 2016 WL 5107019, (E.D. Wis. Jan. 22, 2016).

E. The EEOC's Response to *Seff* and *Flambeau*

In its proposed rule, the EEOC briefly noted its opposition to *Seff*, stating that it did not believe that the safe harbor, as interpreted by the court in *Seff*, "is the proper basis for finding wellness program incentives permissible."[156] The EEOC argued that the ADA "contains a clear 'safe harbor' for wellness programs [§ 12112(d)(4)(B)] . . . Reading the insurance safe harbor as exempting these programs from coverage would render the 'voluntary' provision superfluous."[157] In its final rule, the EEOC expounded on these arguments and its position on the insurance safe harbor in the preamble and its interpretive guidance,[158] and further added an explicit provision in its regulations stating that the safe harbor provisions "applicable to health insurance, life insurance, and other benefit plans do not apply to wellness programs, even if such plans are part of a covered entity's health plan."[159]

As the EEOC noted in the preamble to its final rule, the doctrine devised in *Seff* and applied in *Flambeau* "seems to endorse an almost limitless application of the safe harbor provision,"[160] and taken together, these cases do appear to supply strands of reasoning with the potential to unravel the prohibition of § 12112(d)(4)(A) entirely. Under these cases, a health screening program can meet the requirement of the first step, i.e., can qualify as a "term" of an employer's benefit plan, if the wellness program is required for enrollment and this requirement is described in employee

156 Amendments to Regulations Under the Americans With Disabilities Act, 80 Fed. Reg. 21,659, 21,662 n.24 (proposed Apr. 20, 2015) (to be codified at 29 C.F.R. pt. 1630).

157 *Id.*

158 *See* Regulations Under the Americans With Disabilities Act, 81 Fed. Reg. 31,126, 31,129–31, 31,143 (May 17, 2016) (to be codified at 29 C.F.R. pt. 1630).

159 29 C.F.R. § 1630.14(d)(6) (2016).

160 Regulations Under the Americans with Disabilities Act, 81 Fed. Reg. at 31,131.

handouts.[161] Next, the health screening program can meet the requirement of the second step, i.e., can qualify as "based on underwriting risks, classifying risks, or administering such risks" so long as data from the health screening program is used in the process of developing an insurance plan, and *Seff* suggests a broad interpretation of § 12201(c) under which such process encompasses efforts by an employer to mitigate risks.[162] Since, almost by definition, health screening programs provide data that facilitate efforts to mitigate health risks, essentially the logic of *Seff* and *Flambeau* provides that any health screening program can be required precisely because it is required and a health screening program.

The EEOC's new regulation is a direct reaction to the applications of the safe harbor in *Seff* and *Flambeau*, and is an effort to prevent employers from justifying incentives used in wellness programs by arguing that reducing risks and estimating health care costs fall within the categories of activities permitted by § 12201(c).[163] In other words, "wellness programs" are not "terms of a benefit plan based on underwriting risks, classifying risks, or administering such risks." In its interpretive guidance and in the preamble to its final rule, the EEOC also offered a view into the types of activities that could fall within the safe harbor when it argued, for instance, that "[i]n neither Seff nor Flambeau did the employer or its health plan use wellness program data to determine insurability or to calculate insurance rates based on risks associated with certain conditions—the practices the safe harbor provision was intended to permit."[164]

161 *See supra* note 148 and accompanying text.

162 *See supra* notes 127–136 and accompanying text.

163 *See* Regulations Under the Americans With Disabilities Act, 81 Fed. Reg. at 31,143. "[The safe harbor] does not apply simply because a covered entity asserts that it used information collected as part of a wellness program to estimate, or to try to reduce, its risks or health care costs." *Id.*

164 *Id.* at 31,131; *see also EEOC's Final Rule on Employer Wellness Programs and Title I of the Americans With Disabilities Act*, U.S. EQUAL

F. *Orion*

Only a couple of months after the EEOC issued its new regulations, another court in Wisconsin ruled on the permissibility of an employer's requirement that employees complete a health screening program, upholding the retroactive application of the EEOC's new regulation.[165] In *EEOC v. Orion Energy Systems, Inc.*, the court further concluded that the safe harbor would not apply to the defendant's wellness program regardless of the applicability of the EEOC's regulation, vindicating the arguments underlying the EEOC's new rule.[166] Yet, surprisingly, the court held that the employer's shifting of 100% of the premium equivalent to employees who declined to participate in the wellness program did not render the program involuntary. The court reasoned that "even a strong incentive is still no more than an incentive," and therefore the program was permissible under § 12112(d)(4)(B).[167] Since the EEOC's new rules regarding wellness incentives became effective on January 1, 2017, employers will not be able to set future wellness incentives in reliance on this holding.[168]

EMP'T OPPORTUNITY COMM'N, https://www.eeoc.gov/laws/regulations/qanda-ada-wellness-final-rule.cfm [https://perma.cc/QT3H-P94D] (last visited March 15, 2017). "The ADA's safe harbor provision allows insurers and plan sponsors (including employers) to use information, including actuarial data, about risks posed by certain health conditions to make decisions about insurability and about the cost of insurance. . . . The safe harbor provision does not apply to employer wellness programs, since employers are not collecting or using information to determine whether employees with certain health conditions are insurable or to set insurance premiums." *Id.*

165 EEOC v. Orion Energy Sys., Inc., No. 14-cv-1019, 2016 WL 5107019, at *1, *4–6 (E.D. Wis. Sept. 19, 2016) (discussing the EEOC's rulemaking authority, applying *Chevron* deference to the EEOC's safe harbor regulation, and concluding that the regulation applies retroactively).

166 *Id.* at *6–8.

167 *Id.* at *8.

168 *Id.* (explaining that, under the EEOC's new regulation, "[i]f an employer wishes to incentivize or penalize employees' participation, the

As this Note will explore, however, the court in *Orion* left a critical set of arguments on the table for employers seeking to continue utilizing HRAs and biometric screenings in the same manner as was at issue in *Seff*, *Flambeau*, and *Orion*—arguments pertaining to the precise application of the prohibition in § 12112(d)(4)(A).

In *Orion*, the EEOC brought an action against the employer alleging that it violated the ADA by requiring employees who elected to enroll in its self-insured health insurance plan to either complete a health screening program or pay 100% of the monthly premium equivalent amount.[169] The health screening program consisted of "a health history questionnaire and biometric screen involving a blood pressure check, height, weight, and body circumference measurement, and blood draw and analysis."[170] Like the employers in *Seff* and *Flambeau*, Orion only received information from its health screening program in the form of anonymous, aggregated data that "allowed Orion to see the percentage of participants in its plan who had particular health risks such as high cholesterol."[171]

Orion argued that its wellness program did not violate § 12112(d)(4)(A) for three reasons: (1) the safe harbor

program remains voluntary if the employer provides a financial incentive at or below thirty percent of the total cost for self-only coverage," but noting that "the EEOC does not maintain those aspects of the regulation apply retroactively").

169 *Id.* at *1–2. In 2008, Orion decided to switch from a fully-insured health plan to a self-insured plan and began exploring the use of wellness programs, ultimately implementing a wellness program that required employees to, among other things, complete a health screening program at the beginning of the insurance year or pay the entire monthly premium equivalent. *Id.* This amount was equivalent to $413.43 for single coverage and $1,130.83 for family coverage. *Id.* at *2.

170 *Id.* The case refers to the health screening program as a "health risk assessment." *Id.*

171 *Id.* "Orion did not receive any personally identified information as a result of the HRA. Instead, the questionnaire and blood samples were collected by one vendor (Holy Family Memorial) and sent directly to another vendor (Clinical Reference Lab) with scores then compiled and aggregated by another vendor (Healics)." *Id.*

applied; (2) Orion did not "make inquiries" as prohibited by § 12112(d)(4)(A) because it only received anonymous, aggregated data; and (3) the wellness program was voluntary as employees had a choice regarding whether to participate.[172] As mentioned, the court declined to apply the safe harbor, instead finding the wellness incentives permissible under § 12112(d)(4)(B). In its analysis of the proper application of the insurance safe harbor, the court explained, "the wellness program was not used to underwrite, classify, or administer risk."[173] Instead, Orion claimed that the purpose of receiving data from the health screening program was "to identify common health issues and offer employees educational tools or assistance to improve their health,"[174] and that it "did not use the information it obtained through the wellness initiative to determine the premiums it would charge or determine coverage under the health benefit plan."[175] Orion had additionally argued that § 12201(c)(3), the third prong of the insurance safe harbor applicable to self-insured employers, applied to its actions, and, since § 12201(c)(3) does not include the language of "underwriting risks, classifying risks, or administering such risks," employers with self-insured plans do not need to show that their actions are based on underwriting or classification of risks.[176] In its analysis of the safe harbor provisions, however, the court did not appear to directly address this argument.[177]

Having resolved the case using § 12112(d)(4)(B), the court declined to address Orion's remaining alternative

172 *Id.* at *4.

173 *Id.* at *7.

174 *Id.* at *2.

175 *Id.* at *7.

176 Defendant's Memorandum of Law in Support of its Motion for Summary Judgment at 15–16, EEOC v. Orion Energy Sys., Inc., No. 14-CV-1019, 2015 WL 11197964 (E.D. Wis. Dec. 1, 2015).

177 *See Orion*, 2016 WL 5107019, at *6 (quoting instead §§ 12201(c)(1) and (2)).

argument.[178] Orion had argued that its health screening program did not consist of unlawful medical examinations or disability-related inquiries under § 12112(d)(4)(A) because it never received its employee's individual results.[179] To support this argument, Orion reasoned that the purpose of § 12112(d)(4)(A)'s prohibition is to prevent employers from identifying disabled persons, and that this concern is not implicated if the employer only obtains anonymous aggregated data.[180] As further support, Orion cited *Patten v. State*,[181] a recent case from the Court of Appeals of Oregon that held that an employer did not "make inquiries" regarding disabilities by asking employees to complete an HRA when the employer only received aggregated, de-identified data.[182] In its resolution of a case directly comparable to *Barnes*, *Seff*, and *Flambeau*, therefore, the court in *Patten* honed in on a point of interpretation taken for granted in other cases: whether a health screening requirement actually violates § 12112(d)(4)(A)'s prohibition such that it requires an exemption under another provision of the ADA, such as § 12112(d)(4)(B) or § 12201(c). Taking the view of the court in *Patten*, for instance, the court in *Barnes* might have resolved the case without reference to § 12201(c). Instead, the court might have reasoned that the employer did not "make inquiries of an employee as to whether such employee is an individual with a disability"[183] as the employer was only asking that its employees provide medical information to an insurance provider and was not itself acquiring that information.[184]

178 *Id.* at *4 & n.1.

179 Defendant's Memorandum of Law in Support of its Motion for Summary Judgment, *supra* note 176, at 16.

180 *Id.* at 18.

181 359 P.3d 469 (Or. Ct. App. 2015), *review denied sub nom.* Van Patten v. State, 368 P.3d 26 (Or. 2016).

182 *See id.* at 482–84.

183 42 U.S.C. § 12112(d)(4)(A) (2012).

184 *See* Barnes v. Benham Grp., 22 F. Supp. 2d 1013, 1017 (D. Minn. 1998) (explaining how the insurance enrollment forms were collected).

G. Distillation of Issues

The safe harbor protects disability-related distinctions in health insurance that are actuarially justified and "based on bona fide risk classification,"[185] and disability-related inquiries and medical exams may be utilized in the insurance underwriting process. When the court in *Seff* stated that the safe harbor provisions "collectively refer to the process of collecting information about the health of the insured in order to assess risks so the insurer may accurately establish premiums—in other words: the process of developing insurance plans,"[186] it elided a core inference in its analysis. More precisely, the language of the safe harbor refers to the actions of underwriting, classifying, and administering risks, and of establishing terms of a bona fide health insurance plan—courts have inferred that the process of collecting health information from insured employees is an implicit component of these insurance activities and therefore have, to various extents, concluded that the safe harbor also protects activities involving medical exams and inquiries.

As reflected in the discussion above, the question of whether and how the safe harbor "should apply to wellness programs" has produced inconsistent answers. As a response to the flawed framework in *Seff*, the EEOC's new rule in 29 C.F.R. § 1630.14(d)(6) seems clear: the safe harbor provisions "do not apply" to "wellness programs" in the way that *Seff* and *Flambeau* applied those provisions to wellness programs.[187] Yet, though the EEOC presented this repudiation "in no uncertain terms,"[188] framing the issue as simply one of whether the safe harbor provisions "do not apply"[189] or "shall apply"[190] to "wellness programs" glosses

185 *See supra* Section III.A.

186 Seff v. Broward Cty., 778 F. Supp. 2d 1370, 1374 (S.D. Fla. 2011).

187 *See supra* Section III.E.

188 EEOC v. Orion Energy Sys., Inc., No. 14-cv-1019, 2016 WL 5107019, at *4.

189 29 C.F.R. § 1630.14(d)(6) (2016).

over the heart of the controversy: the different constructions of the safe harbor discussed above ultimately boil down to differences in opinion as to how closely disability-related inquiries and medical exams must be related to the development of bona fide insurance plans to fall within the ambit of § 12201(c). It cannot be that the safe harbor protects all medical inquiries and exams that could conceivably become part of decisionmaking for an employer considering health insurance options (as suggested by the decision in *Seff*)—otherwise, the safe harbor would entirely engulf the prohibition of § 12112(d)(4)(A). Yet, some medical inquiries are essential enough to bona fide risk classification to justify gaining the protection of § 12201(c) (as evidenced by the decision in *Barnes*);[191] the ADA does not disrupt how the insurance industry does business.[192]

Though § 1630.14(d)(6) rejects the holdings of *Seff* and *Flambeau*, it does not appear to disturb the problematic way in which the courts and parties have framed the questions presented by these cases. Additionally, it appears to rest on an assumption that employers and insurers do not use data from health screening programs, which may be components of broader wellness programs, in the underwriting process.[193] As such, the new rule does not fully address the complexities posed by factual scenarios such as the one in *Flambeau*, which presented a test case apt for the development of a nuanced analysis of the limits of and overlaps between the provisions in § 12112(d)(4) and § 12201(c). A comparison of the facts in *Flambeau* and those in *Barnes* illuminates some of the open questions that ought to be addressed in order to formulate a comprehensive and coherent doctrine respecting the safe harbor's application to health screening programs. In its resolution of the case, the court in *Flambeau* might have offered, for instance, an analysis of the salient

190 Preserving Employee Wellness Programs Act, H.R. 1313, 115th Cong. § 3(a)(1)(C) (2017).

191 *See supra* Section III.B.

192 *See supra* note 100.

193 *See supra* note 164 and accompanying text.

distinctions between *Flambeau* and *Barnes*—the facts that the employer in *Flambeau* offered a self-insured plan, required employees to complete a biometric screening in addition to a health questionnaire, and used the data from its health screening program in conjunction with its wellness management offerings instead of solely for the development of its health plan—to determine whether these distinctions do or should qualify the applicability of the safe harbor to a health screening program. This opportunity was lost, however, when the court proceeded in the wake of the reasoning in *Seff*.

An additional wrinkle is the issue of how to apply § 12112(d)(4)(A) in cases where the employer does not receive individualized medical information about its employees—an argument left on the table by the court in *Orion*. Though the parties in *Patten* agreed that the financial incentives attached to the HRA in that case rendered participation in the HRA "involuntary,"[194] the court held that the HRA did not pose disability-related inquiries as a threshold matter and therefore did not violate § 12112(d)(4)(A). Essentially, employers in cases like *Seff* and *Flambeau*, who only receive de-identified aggregate data from their health screening programs, could attempt to use the line of argument advanced in *Patten* to sidestep entirely questions of whether their health screening programs are "voluntary" under § 12112(d)(4)(B) or breach the maximum allowable incentives set forth by the EEOC's new regulation. The next Part begins with an analysis of this issue before proceeding to outline a framework for determining the extent to which

194 Patten v. State, 359 P.3d 469, 472 (2015), *review denied sub nom.* Van Patten v. State, 368 P.3d 26 (2016) ("Although an employee's eligibility for state sponsored health insurance does not depend on whether the employee has completed the assessment, those who do not complete it pay more for their insurance than those who do. The difference is currently $17.50 per month for individuals or $35.00 per month for couples. Nonparticipants also currently have a deductible that is $100.00 larger than participants. The parties agree that, because of this financial disincentive, participation in the assessment is not 'voluntary' as that term is defined in the ADA.").

the provisions of the safe harbor provide protection to medical inquiries and exams comprising health screening programs.

IV. INTERPRETING § 12112(D)(4)(A)'S PROHIBITION AND NAVIGATING THE INSURANCE SAFE HARBOR

This Part of the Note begins by addressing Orion's and the EEOC's arguments in the *Orion* case about the proper interpretation of § 12112(d)(4)(A)'s prohibition on disability-related inquiries and medical examinations, and outlines a construction of the provision in light of the text, legislative history, and purpose of the ADA. This Part then analyzes how a proposed construction of § 12112(d)(4)(A) and § 12201(c) would apply to the type of wellness programs at issue in cases such as *Seff*, *Flambeau*, and *Orion*, and identifies possible concerns with how wellness programs will be implemented and designed in the future.

A. Interpreting § 12112(d)(4)(A)

The ADA provides 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."[195] The court in *Patten* confronted the question of whether the defendants did "make inquiries" regarding disabilities, despite the fact that neither defendant ever received any individual employee responses from the HRA at issue.[196] After noting that "[n]either the parties nor we have found precedent from any jurisdiction, or any other source, examining the precise question at issue here,"[197] the court proceeded to construct an interpretation of § 12112(d)(4)(A)'s language based on the overall statutory scheme and

195 42 U.S.C. § 12112(d)(4)(A) (2012); *see supra* notes 56–63 and accompanying text.

196 *Patten*, 359 P.3d 473–74.

197 *Id.* at 473.

purposes of the ADA.[198] While the HRA at issue undeniably asked employees to answer questions, the court reasoned that it was ambiguous whether those questions were "'inquiries' in the unique circumstances of an anonymous health assessment questionnaire."[199] The court determined that the plaintiffs' interpretation that the HRA fell within § 12112(d)(4)(A)'s prohibited "inquiries" did not align with the purpose of the ADA's "overall statutory scheme" to prevent employers from discriminating against persons who are disabled.[200] The court concluded that "the ADA governs relationships between employers and employee" and "banning the flow of information between employees and third parties who are not employers" "introduces a foreign and extraneous concept."[201] Therefore, according to the court, the plaintiffs appeared to be attempting to "conscript [the ADA] to their own uses instead of the uses which motivated Congress to enact it."[202]

In reaching its conclusion, the court looked to the dictionary definition of "inquiry," which it reported to be "the act or an instance of seeking truth, information, or knowledge about something."[203] The court reasoned that if an entity asks a question it knows it will not receive a response to, then it "makes no sense to regard the questioner as 'seeking' truth, information or knowledge about anything."[204] To illustrate its logic, the court suggested that "[b]y analogy, a person requesting that a friend donate money to a charity cannot be said to be 'seeking' that money, because the person has no expectation of receiving it."[205] The soundness of this analysis of the dictionary definition and the suitability of the analogy is debatable; the defendants used the aggregated

198 *Id.*

199 *Id.* at 473–74.

200 *Id.* at 474.

201 *Id.*

202 *Id.*

203 *Id.* at 473–74.

204 *Id.* at 474.

205 *Id.*

results of the health screening program and implemented it with the aim of "encourag[ing] employees to adopt beneficial health habits, thereby, presumably, reducing insurance costs,"[206] so perhaps it would be more apt to analogize their actions to "a person requesting that a friend donate money to a charity" for a cause that directly benefits that person—this person has no expectation of receiving the money but expects to receive benefits from the donation nonetheless. The defendants in this case, and in the foregoing cases, were seeking to have employees provide personal health information for the employers' purposes (e.g., to reduce health costs), though they used third party entities to handle the information.

It is undeniable that the statutory language, which prohibits inquiries "*of an employee* as to *whether such employee* is an *individual with a disability*,"[207] could accommodate an interpretation that *the receipt per se* by an employer of aggregated, de-identified information from an HRA does not fall within the scope of § 12112(d)(4)(A)'s prohibition. This conclusion is further supported by the ADA's legislative history, which indicates that the prohibitions on disability-related inquiries in § 12112(d) were motivated by a concern that even identification alone of a disability could serve to stigmatize a person with a disability.[208] Congressional reports provide as an example that "the individual with cancer may object merely to being identified, independent of the consequences."[209] Arguably, if an employer has no access to individually identifiable medical information, a request for aggregated, anonymous data is not a question "likely to elicit information about a disability"[210] with respect to individual employees.

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206 *Id.* at 472 (explaining that the aggregated results were used "to help in the design of future health plan offerings").

207 42 U.S.C. § 12112(d)(4)(A) (2012) (emphasis added).

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

209 *Id.*

210 *EEOC Enforcement Guidance*, *supra* note 60.

In its motion for summary judgment, Orion attempted to supplement the reasoning in *Patten* by arguing that § 12112(d)(4)(C), regarding the confidentiality of information obtained under § 12112(d)(4)(B), would be "rendered superfluous unless the prohibitions on medical examinations and inquiries only applied if the employer receives the results."[211] Orion reasoned that § 12112(d)'s prohibitions necessarily imply the employer will obtain individual medical results because "otherwise there would be no need to require by statute that the results be treated on a confidential basis and kept in a separate employee medical file."[212] This argument is flawed since applying § 12112(d)(4)(A)'s prohibition to cover actions involving both types of information collection would not neutralize the need to provide confidentiality protections for instances where an employer collects individually identifiable information. Even so, § 12112(d)(4)(C) does lend some additional support to the position that § 12112(d)(4)(A)'s prohibition is directed at the use or acquisition by an employer of individually identifiable health information, and the pure act of acquiring aggregated, de-identified information therefore should not be considered an "inquiry" under § 12112(d)(4)(A).

But even if the receipt of aggregated, anonymous health information is not itself a violation of § 12112(d)(4)(A), to characterize the actions of the employers in *Patten* and *Orion* as simply such would be devious. In its opposition to Orion's motion for summary judgment, for instance, the EEOC argued that, even if the acquisition by an employer of aggregated data does not qualify as an "inquiry," "Orion's *agent* that compiled the aggregate information indisputably had access to the individualized medical data," and since the ADA defines employer to include "any agent of such person,"

211 Defendant's Memorandum of Law in Support of its Motion for Summary Judgment, *supra* note 176, at 17.

212 *Id.*

Orion's actions violated § 12112(d)(4)(A).[213] Insofar as Orion's wellness program vendors had no power to affect employment decisions, an employer could argue that it would be improper to consider them "agents" for the purpose of bringing them within § 12111(5)(A)'s definition of "employer."[214] However, whether or not the wellness vendors are "agents" for purposes of being subject to liability under the ADA, the employers in these cases did not only receive aggregated employee health data but also directed the collection, albeit by third party administrators, of the individualized health information. Perhaps an employer's making any request of employees to provide personal medical information to any entity, employer or not, should fall within § 12112(d)(4)(A)'s prohibition.[215] In short, it does not necessarily flow from the premise that the receipt of aggregated, de-identified information does not violate § 12112(d)(4)(A) that therefore there is no issue under § 12112(d)(4)(A) whenever there has been such receipt, regardless of other facts—such as whether the information was used in some way on behalf of the employer or to serve the employer's purposes in ways that result in the disparate treatment of disabled persons.

213 EEOC's Memorandum in Opposition to Orion's Motion for Summary Judgment at 20, EEOC v. Orion Energy Sys., No. 14-1019, 2016 WL 5107019 (E.D. Wis. January 4, 2016) (emphasis added).

214 *See, e.g.*, Satterfield v. Tennessee, 295 F.3d 611, 615–19 (6th Cir. 2002) (discussing the meaning of "agent").

215 *Cf.* 42 U.S.C. § 12112(b) (2012) (providing that to "discriminate against a qualified individual on the basis of disability" includes "participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity's qualified applicant or employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs)"); *Satterfield*, 295 F.3d at 618 (noting that employers "do not escape their legal obligations under the ADA by contracting out certain hiring and personnel functions to third parties").

The "overall statutory scheme" of the ADA centers on preventing disability-related discrimination, as the court in *Patten* observed,[216] but the language of § 12112(d)(4)(A) reflects a decision by Congress to go further—Congress chose to prophylactically restrict the means for attaining employee health information, rather than just the acquisition of individually identifiable information by the employer. The exception provided in § 12112(d)(4) is not simply that an employee's medical information be kept confidential;[217] the statute also requires that "acceptable examinations and inquiries" be voluntary *and* part of an employee health program, *as well as* that information obtained from such acceptable examinations and inquiries be treated as confidential medical records.[218] The particular phrase "make inquiries" might be susceptible to multiple constructions,[219] but "[w]ords are not pebbles in alien juxtaposition; they have only a communal existence; and not only does the meaning of each interpenetrate the other, but all in their aggregate take their purport from the setting in which they are used."[220] Though the court in *Patten* duly noted that a court should interpret statutory language "in their context," it did not appear to analyze the statutory context of the provision in

216 Patten v. State, 359 P.3d 469, 474 (2015), *review denied sub nom.* Van Patten v. State, 368 P.3d 26 (2016).

217 *Cf.* 42 U.S.C. § 12112(d)(3) (2012) (providing that employers "may require a medical examination after an offer of employment has been made to a job applicant and prior to the commencement of the employment duties of such applicant" if, among other requirements, the information obtained regarding the applicant's medical condition or history "is treated as a confidential medical record").

218 42 U.S.C. § 12112(d)(4)(B), (C) (2012);

219 *See, e.g.*, EEOC's Memorandum in Opposition to Orion's Motion for Summary Judgment, *supra* note 213, at 19–20; Defendant's Reply Memorandum of Law in Support of its Motion for Summary Judgment at 11–12, EEOC v. Orion, 208 F. Supp. 3d 989 (E.D. Wis. 2016) (No. 14-cv-1019).

220 King v. St. Vincent's Hosp., 502 U.S. 215, 221 (1991) (explaining the "cardinal rule that a statute is to be read as a whole"); *see also, e.g.*, Brown v. Gardner, 513 U.S. 115 (1994) ("Ambiguity is a creature not of definitional possibilities but of statutory context.").

reaching its conclusion that the term "inquiries" is "ambiguous."[221] A holistic and internally consistent reading of the provisions of § 12112(d)(4) would recognize that the provisions together, first, prohibit employers from requiring that employees complete medical examinations, "including . . . medical histories,"[222] and from asking questions about an employee's health, and, second, enumerate a particular exception for voluntary medical examinations and voluntary medical histories that are part of an employee health program. The notion, meanwhile, that an implicit exception to the prohibition in § 12112(d)(4)(A) arises when the employer receives information from medical inquiries only in the aggregate contradicts the specifically enumerated requirements of the exception in § 12112(d)(4)[223] and implies an inconsistent application of the statute to medical inquiries as opposed to medical examinations, the explanation or support for which is not readily apparent based on the statutory language and context of § 12112(d)(4)'s provisions.[224]

Moreover, if concerns about the potential stigma from identification alone motivated the creation of § 12112(d)(4)(A),[225] it is difficult to argue that collecting personal health information in order to facilitate targeted wellness offerings, for instance, would not implicate concerns of the same quality and degree simply because the employer itself does not receive individually identifiable information. For example, a health screening program that requires employees who do not "pass" a biometric screening test involving height, blood pressure, body mass index, blood sugar, and cholesterol measurements to take a "multi-week online health-improvement course" or pay an extra $600 per

221 *See Patten*, 359 P.3d at 473–74 (appearing instead to interpret "context" as the specific factual circumstances of a case).

222 § 12112(d)(4)(B).

223 §§ 12112(d)(4)(B), (C).

224 *See* § 12112(d)(4)(A); *cf.* § 12112(d)(4)(2) (carving out an exception for acceptable preemployment inquiries but not medical examinations).

225 *See supra* notes 208–209 and accompanying text.

year for health insurance[226] may just as effectively stigmatize employees even though, technically, an employer could assert that its wellness vendor is the entity conducting the program and handling the information, and therefore the employer itself has not directly identified the health issues of any one employee.[227]

The interpretation of "inquiries" advanced by the court in *Patten* would further produce an absurd result whereby § 12112(d)(4)(B)'s requirements for medical exams and inquiries that are part of an employee health program would have no application at all so long as an employer uses wellness vendors to carry out those medical exams and inquiries that are part of an employee health program. In other words, extending the logic of the holding in *Patten*, an employer might argue that an HRA does not run into the prohibition on disability-related inquiries in § 12112(d)(4)(A) if the employer does not receive individualized information from the HRA, and therefore, the wellness program would not be subject at all to the incentive limits that the EEOC's new regulations place on participatory wellness programs. An even bolder employer might attempt to argue that even where it requires employees to undergo biometric screening, e.g., blood tests or in-person medical exams, it would not violate § 12112(d)(4)(A)'s prohibition on requiring medical examinations if it does not acquire the personal health information of its employees as a result,[228] though this

226 Anderson, *supra* note 30 (providing a personal anecdote about such a health screening program).

227 *Cf.* Madison, *supra* note 1, at 422–23 ("One scholar has suggested that the focus on individual responsibility for health 'creates new "health deviants" and 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."). Employees might also be justifiably concerned that an employer could nonetheless draw conclusions from anonymized data or combine such data with information about other sources to make inferences about their health.

228 *See* Defendant's Reply Memorandum of Law in Support of its Motion for Summary Judgment, *supra* note 219, at 12 ("[I]f Congress

argument would be quite difficult to make in light of the plain language of the provision; even if there is ambiguity with respect to the meaning of "make inquiries," the statute clearly states an employer "shall not require a medical examination."[229]

The language of an analogous provision in GINA might inform on how the language of § 12112(d)(4)(A) could be clarified to speak more clearly to the types of wellness program practices commonly found at present. GINA provides that it "shall be an unlawful employment practice for an employer to request, require, or purchase genetic information with respect to an employee or a family member of the employee . . . ."[230] While this language falls under a section entitled "Acquisition of genetic information," the exception in § 2000ff-1(b)(2) suggests that the drafters considered a request for an employee to provide genetic information to a third party to fall under this prohibition. Specifically, § 2000ff-1(b)(2) states that an employer may request genetic information where the employer is offering a wellness program, but only if (1) the employee provides "prior, knowing, voluntary, and written authorization," (2) only the employee and health professional involved in providing the services of the wellness program receive individually identifiable information, and (3) any individually identifiable information is not disclosed to the employer except in aggregate terms.[231] The components of this exception suggest that the drafters of GINA specifically considered a situation wherein an employer requests an employee participate in a wellness program and only

desired to make it unlawful under the ADA to request a medical examination . . . it knows to use the term 'request.' When Congress uses the term 'require' like in the ADA's § 12112(d)(4)(A), Congress is making unlawful the next step in the process—obtaining the results of the medical examination and inquiry—not the prior step in the process (requesting the medical examination).").

229 42 U.S.C. § 12112(d)(4)(A) (2012).

230 42 U.S.C.§ 2000ff-1(b) (2012).

231 § 2000ff-1(b)(2).

receives data from the wellness program in aggregate terms, and still chose to explicitly require that the provision of genetic information by the employee be voluntary. GINA is a separate law from the ADA, but the EEOC could consider issuing interpretive guidance or clarifying rules providing that §§ 12112(d)(4)(A) and (B) should be read together to impose the same manner of requirements and restrictions on employers as GINA's prohibitions do in the context of prohibiting employment discrimination based on genetic information.[232]

In sum, the plain language of the ADA, its legislative history, and logic do not comfortably comport with the holding of *Patten*. This analysis suggests that the determination of whether there is an issue under § 12112(d)(4)(A) should not hinge on the nature of an employer's receipt of information; instead, if an employer requires employees to complete a medical examination or health questionnaire so that their personal health information can be collected and used for an employer-sponsored program, for whatever purpose, the employer has made an "inquiry" that it must justify, such as by arguing that the inquiry meets the requirements of §§ 12112(d)(4)(B) and (C) or that it is protected by the safe harbor provisions in § 12201(c). The foregoing arguments suggest that an employer should not escape the ambit of § 12112(d)(4)(A) solely by asserting that it received health screening data

232 Ironically, a potential counterargument to this proposal is contained in the EEOC's own briefing in *Orion*. The EEOC argued, citing to 42 U.S.C. § 2000ff-3(b), that "[t]he ADA bars requests for medical information and examinations, not just acquisition of the information. Congress knew how to prohibit acquisition of information if that is what it intended to do." EEOC's Memorandum in Opposition to Orion's Motion for Summary Judgment, *supra* note 213, at 21. It is not at all clear the mileage provided by this argument considering that § 2000ff-3(b) contains the word "request." Ultimately, the question boils down to whether "request[ing] . . . information with respect to an employee" means or should carry the same meaning as "[making] inquiries of an employee," and whether that meaning prohibits only the collection of information or also the direction of collection of such information.

only in aggregated, de-identified terms. At the same time, however, an employer would be standing on strong ground in arguing that the pure receipt of aggregated, de-identified health information does not run afoul of § 12112(d)(4)(A). Indeed, an employer could cite to the EEOC's new regulations and interpretive guidance, which provide that information collected by a wellness program may be provided to an ADA covered entity in aggregate terms that do not disclose, or are not reasonably likely to disclose, the identity of any employee,"[233] and there are "no restrictions on the use/disclosure of health information that has been de-identified in accordance with the HIPAA Privacy Rule."[234] The employer would still need, however, to find an exemption in the ADA for the act of asking an employee to complete an HRA or a biometric screening. One possibility is § 12112(d)(4)(B), under which the employer would be required to comply with the wellness incentive limits set forth in the EEOC's new regulations. Another possibility, as the next Section explores in more detail, is inuring the requests under § 12201(c), the insurance safe harbor.

B. Navigating the Insurance Safe Harbor

The EEOC sought in its final rule to foreclose any application of the insurance safe harbor as occurred in *Seff* and *Flambeau* through a regulatory provision declaring that: "The 'safe harbor' provisions . . . applicable to health insurance, life insurance, and other benefit plans do not apply to wellness programs, even if such plans are part of a covered entity's health plan."[235] This Section offers a more nuanced navigation of the safe harbor.

The framework of analysis suggested here for determining whether a health screening program qualifies for the protection of § 12201(c) begins with the question of whether construing the ADA to prohibit or restrict a health

233 29 C.F.R. § 1630.14(d)(4)(iii) (2016).

234 29 C.F.R. Pt. 1630, App. § 1630.14(d)(4) (2016).

235 29 C.F.R. § 1630.14(d)(6) (2016).

screening program would prohibit or restrict an insurer or employer (or other entity specified in § 12201(c)) from conducting the activities specified in the safe harbor provisions.[236] Orienting the issue in this manner perhaps seems like an obvious proposition, but this is not quite how the question has been framed in the safe harbor cases discussed above. With respect to the health questionnaire in *Barnes*, for example, the court might have reasoned that construing the ADA to prohibit the questionnaire would have prohibited or restricted the insurer from underwriting and classifying risks and interfered with the way the insurance industry does business, contravening the first provision in the insurance safe harbor, § 12201(c)(1). The court couched its analysis, instead, in statements about the purpose of the health questionnaire and its alignment with the purpose of the insurance safe harbor ("to permit the development and administration of benefit plans *in accordance with accepted principles of risk assessment*").[237] Later, in *Seff*, the court cited this language to conclude that the language of § 12201(c) refers to "the process of developing insurance plans."[238] Since the defendant in *Seff* could use the health screening data to "develop" and "design" future benefit plans, the court held that the health screening program was protected by the safe harbor.[239] Carried by this language, the application of the safe harbor in *Seff* drifted away from the lifting of prohibitions under the ADA in a limited manner—solely to permit activities essential to the provision of insurance—to the permitting of activities broadly relatable

236 *See* 42 U.S.C. § 12201(c) (2012) ("Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict . . . .").

237 Barnes v. Benham Grp., Inc., 22 F. Supp. 2d 1013, 1020 (D. Minn. 1998); *see supra* text accompanying notes 110–114.

238 Seff v. Broward Cty., 778 F. Supp. 2d 1370, 1374 (S.D. Fla. 2011), *aff'd sub nom.* Seff v. Broward Cty., Fla., 691 F.3d 1221 (11th Cir. 2012); *see supra* text accompanying notes 127–132.

239 *See Seff*, 778 F. Supp. 2d at 1374; *see supra* text accompanying notes 133–136.

to the process of establishing an insurance plan. This constituted an improper expansion of the safe harbor.[240]

In circumstances involving an insured health insurance plan, the first and second prongs of the insurance safe harbor are applicable.[241] The question under the first prong should be whether applying § 12112(d)(4) to the medical exams or inquiries in a certain case would prohibit or restrict the underwriting process of the insurer. If so, the medical exams and inquiries are within the protective ambit of § 12201(c)(1). This determination would depend on whether, for instance, the insurer requires an individual to take a physical exam or fill out a health care questionnaire in order to take the health factors of individual employees into account when establishing blended, aggregate rates for a group health plan.[242] Regulations pertaining to the design

240 In *Flambeau*, the court noted that the EEOC had contended "that the court is compelled by traditional principles of statutory interpretation to construe § 12201(c)(2) narrowly because it is an 'exception' or 'proviso,' and that by contrast, '[t]he ADA is a remedial statute . . . [and] must be construed with all the liberality necessary to achieve such purposes," but the court stated "[the EEOC did not] explain the specific manner in which § 12201(c)(2) should be construed narrowly or how a narrow construction would result in the wellness program requirement's falling outside the safe harbor." EEOC v. Flambeau, Inc., 131 F. Supp. 3d 849, 854 (W.D. Wis. 2015), *aff'd*, 846 F.3d 941 (7th Cir. 2017).

241 *See* § 12201(c)(1)–(2); H.R. REP. NO. 101-485, Part 2, at 137 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 421.

242 That is to say that, though the laws pertaining to the permissibility of certain insurance practices have changed since *Barnes* was decided, to the extent insurance laws permit a health insurance issuer or self-insured employer to (1) require an individual to take a physical exam or fill out a health care questionnaire in order to enroll in a group health plan and (2) take health factors of individual employees into account when establishing blended, aggregate rates for group health plans, *see, e.g.*, U.S. DEPT. OF LABOR, YOUR HEALTH PLAN AND HIPAA . . . MAKING THE LAW WORK FOR YOU 16-17 (2013); *The HIPAA Nondiscrimination Requirements*, U.S. DEPT. OF LABOR, https://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html [https://perma.cc/Y9V4-K44Y] (last visited March 15, 2017) (noting the permissibility of requiring that individuals complete health care questionnaires but not explicitly

and provision of insurance plans, as well as typical industry practices, would bear on this determination; for instance, it would seem unlikely that a defendant would be able to successfully invoke the protection of § 12201(c)(1) in a case involving a small group health plan subject to adjusted community rating requirements.[243] This may also be a moot question in cases where, as typical in large group employment situations, an issuer does not use medical underwriting but instead determines premium rates based on an employer's prior claims experience.[244]

The question under the second prong, meanwhile, would be whether applying § 12112(d)(4) to the medical exams or inquiries in a certain case would prohibit or restrict an employer "from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks." Construed narrowly, while the safe harbor's first prong provides that the ADA shall not restrict an insurer from providing a plan with terms or

addressing requirements to take physical examinations), the ADA does not prohibit these practices.

243 Under the ACA, health plans in the individual and small group market are allowed to adjust premiums only on the basis of (1) individual or family enrollment, (2) geographic area, (3) age, and (4) tobacco use. *See generally, e.g.*, KAISER FAMILY FOUND., HEALTH INSURANCE MARKET REFORMS: RATE RESTRICTIONS (2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf [https://perma.cc/HAN8-MXNK]; CENTERS FOR MEDICARE & MEDICAID SERVICES, REPORT TO CONGRESS ON THE IMPACT ON PREMIUMS FOR INDIVIDUALS AND FAMILIES WITH EMPLOYER-SPONSORED HEALTH INSURANCE FROM THE GUARANTEED ISSUE, GUARANTEED RENEWAL, AND FAIR HEALTH INSURANCE PREMIUMS PROVISIONS OF THE AFFORDABLE CARE ACT (2014), https://www.cms.gov/research-statistics-data-and-systems/research/actuarialstudies/downloads/aca-employer-premium-impact.pdf [https://perma.cc/87YJ-EJZ5].

244 *See, e.g.*, *Risk Classification in the Voluntary Individual Health Insurance Market*, AM. ACAD. ACTUARIES (Mar. 1, 2009), http://www.actuary.org/pdf/health/risk_mar09.pdf [https://perma.cc/7JHU-UGR9]; *Consumer Guide to Group Health Insurance*, NAHU, http://www.nahu.org/consumer/groupinsurance.cfm (last visited Mar. 6, 2017) [https://perma.cc/UA5J-XQGW].

provisions that are disability-related distinctions, the safe harbor's second prong provides simply that an employer may adopt such a plan with legitimate disability-related distinctions without running afoul of the ADA's nondiscrimination principles.[245] Applying the ADA to medical exams and inquiries does not restrict an employer's ability to adopt a health insurance plan containing disability-based distinctions that are the product of legitimate underwriting practices, except possibly to the extent that doing so would prevent the insurer from "underwriting risks, classifying risks, or administering such risks."[246] Therefore, though information from medical exams and inquiries may be relevant to an employer's decision to adopt a particular insurance plan, to the extent that the safe harbor provisions should be construed narrowly,[247] the second prong should offer no additional protection to medical inquiries or exams that are not already within the protective ambit of the first prong.

The third prong of the safe harbor applies to self-insured or self-funded health plans,[248] under which "the employer directly assumes the liability of an insurer."[249] Employers with self-funded plans usually hire a third party administrator to provide services such as designing the benefit plan, estimating costs associated with the plan,

245 *Cf.* U.S. EQUAL EMP'T OPPORTUNITY COMM'N, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (1993), 1993 WL 1497027, at *1–3.

246 42 U.S.C. § 12201(c)(1)–(2) (2012).

247 *See supra* note 240.

248 § 12201(c)(3); *see also, e.g.*, H.R. REP. NO. 101-485, Part 2, at 137 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 421.

249 U.S. EQUAL EMP. OPPORTUNITY COMM'N, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (1993), 1993 WL 1497027, at *3 n.3 ("Insured health insurance plans are regulated by both ERISA and state law. Self-insured plans are typically subject to ERISA, but are not subject to state laws that regulate insurance.").

collecting premiums from employees, and processing medical claims; generally, self-funding employers also purchase stop loss insurance policies to mitigate the risk of loss from high cost and high frequency claims.[250] Self-funding is more common among larger employers than smaller employers,[251] but because a self-insured small group employer is not subject to a number of regulatory requirements under the ACA, including its prohibition on medical underwriting and community rating rules, small employers may be increasingly deciding to self-fund.[252] Since the third prong of

250 *See, e.g.*, Robert C. Pozen & Anant Vinjamoori, *Report: Incentives for Small firms to Self Fund Their Healthcare Plans*, BROOKINGS (Nov. 19, 2014), https://www.brookings.edu/research/incentives-for-small-firms-to-self-fund-their-healthcare-plans/ [https://perma.cc/XA6A-C9VF]; NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, WHITE PAPER: STOP LOSS INSURANCE, SELF-FUNDING AND THE ACA 2 (2015), http://www.naic.org/documents/SLI_SF.pdf [https://perma.cc/XPH6-UMZH].

251 *See, e.g.*, Pozen & Vinjamoori, *supra* note 250 ("Most large firms self fund their healthcare programs, rather than buy insurance. By contrast, just 8%-16% of small firms (between 1 and 100 full-time employees) choose to self-fund.").

252 *See, e.g.*, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, *supra* note 250, at 1–2 ("One concern about the potential impact of the ACA is that if employers—particularly small employers, with younger, healthier employees—self-fund, thereby avoiding some of the requirements of the ACA, it will leave the older, sicker population to the fully insured, small employer group market. This concern is based on the differing underwriting standards. Because the small group market requires modified community rating and the self-funded market is allowed to reflect an employer's risk, it is assumed that self-funded plans will be attractive to low-risk groups . . . there has been demonstrated interest in discussing self-funding in the small group market. One indication of this interest that the states are seeing is the development of stop loss insurance policies specifically designed to market to small employers."); UC BERKELEY LABOR CENTER, AFFORDABLE CARE ACT: SUMMARY OF PROVISIONS AFFECTING EMPLOYER-SPONSORED INSURANCE 5 tbl.1 (2014), http://laborcenter.berkeley.edu/pdf/2010/ppaca10.pdf [https://perma.cc/A3F2-DXH7]; Pozen & Vinjamoori, *supra* note 250; *Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees*, AM. ACAD. ACTUARIES (Mar. 2, 2015),

the safe harbor "make[s] it clear that [the ADA] will not disrupt . . . the current regulatory structure for self-insured employers,"[253] the question under the third prong should be—akin to the question under the first prong—whether applying § 12112(d)(4) to medical exams or inquiries in a certain case would prohibit or restrict the plan design process of a self-insured employer.

The upshot of this analysis is that insurance practices that are regulated by state and federal insurance laws are removed from the application of ADA provisions by the insurance safe harbor. If the use of medical questionnaires and exams to underwrite risks is consistent with the applicable insurance laws, an employer who sponsors a plan developed through such activities would be protected from allegations that it violated § 12112(d)(4)(A) by § 12201(c), as was the employer in *Barnes*. And an employer that receives aggregated, de-identified data from these exams or questionnaires, as allowed under HIPAA's privacy rules, arguably has done nothing to violate § 12112(d)(4)(A) or to evade the purposes of the ADA of preventing employment discrimination on the basis of disability.[254] In short, though the reasoning in a case like *Flambeau* might be flawed, the ultimate practices at issue could still be allowable even under a narrow interpretation of the insurance safe harbor—allowing for employers to obtain anonymous, aggregated data, whether to estimate future health care costs or design wellness programs, from HRAs and biometric screenings without violating the ADA.

A side effect of how the doctrine concerning the application of the ADA to wellness programs has developed may be to nudge employers to increase usage of health

http://www.actuary.org/files/Small_group_def_ib_030215.pdf [https://perma.cc/4ZSN-SE4P].

253 H.R. REP. NO. 101-485, Part 2, at 136 (1990), *as reprinted in* 1990 U.S.C.C.A.N. 303, 419.

254 *See* 42 U.S.C. § 12201(c) (2012) (prohibiting the use of the insurance safe harbor provision as subterfuge to evade the purposes of the ADA).

screening data for insurance purposes.[255] Even if, however, the safe harbor protects the medical inquiries and exams comprising a particular health screening program on the basis of their use for insurance underwriting, to the extent that this information might be used for other purposes (e.g., to identify employees for a disease management program),[256] such use for other purposes is not protected by the safe harbor and should arguably be limited. A characteristic of the wellness programs at issue in *Seff* and *Flambeau* was the cross-context use of employee health information, but this aspect was not addressed at all by either court's analysis. One possible approach for policymakers to consider would be to require that employers obtain employees' consent before using their personal health information outside of the insurance context that enabled the collection of that information.[257] As mentioned in Part I, the question of what happens to an employee's personal health information after it is collected is not a trivial one, and the current state of data privacy law does not reach many of the potential ways in which such information may be surprisingly disclosed. Additionally, while HRAs and biometric testing are often

255 *See* Carmen Castro-Pagan, *Employer Groups Don't See Eye to Eye on EEOC Wellness Plan Ruling*, BLOOMBERG BNA: HUMAN RESOURCES REPORT (Sept. 23, 2016), https://www.bna.com/employer-groups-dont-n57982077504/ [https://perma.cc/PZ4R-HD8F] (noting the view of an employee benefits attorney that "[e]mployers that want to assert the safe harbor defense should make sure that their wellness plan is really part of their health plan and that there is evidence that it is used to assist in underwriting, classifying and administering risk under the statutory language and as demonstrated in *Flambeau*"); *see also* Peppet, *supra* note 32, at 155–56 (noting that one "can easily imagine health and life insurers demanding or seeking access to fitness and health sensor data, or home insurers demanding access to home-monitoring system data. As such data become more detailed, sensitive, and revealing, states might consider prohibiting insurers from conditioning coverage on their revelation").

256 *See* Seff v. Broward Cty., 778 F. Supp. 2d 1370, 1372 (S.D. Fla. 2011) (explaining how the health screening data in that case was used to identify employees for a disease management program).

257 *Cf.* Peppet, *supra* note 32, at 151–52 (describing cross-context use constraints in other contexts).

used together as part of health screening programs to gather medical information from employees, there is a basic distinction between biometric screening, which may involve medical examinations, blood tests, and the use of biometric monitoring devices, and a medical questionnaire.[258] Biometric screening is, by nature, more intrusive. Future policymakers should take into consideration such ways in which wellness program design may impact employee privacy, autonomy, and dignity.

V. CONCLUSION

As employee wellness programs continue to evolve in form and use in the workplace, employers will continue to seek guidance from regulatory agencies and the courts. As the EEOC has developed its regulatory approach under the ADA to wellness programs, courts have also endeavored to apply the ADA to wellness programs that present new questions about the applicability of the statute's provisions to business practices that were not common until recently. This Note has reviewed the developing law on the application of the ADA's insurance safe harbor provision to wellness programs. Specifically, it has examined questions and arguments regarding the ADA's prohibition on disability-related inquiries and medical examinations left unaddressed by the case law and the EEOC's recently issued regulation governing wellness incentives. This Note has suggested an integrated approach for applying the ADA to wellness programs, argued that "wellness programs" such as those at issue in *Flambeau* may remain permissible under the ADA's current regulatory framework despite recent court decisions and agency rulemaking, and discussed some of the persisting issues with employing the ADA to address employees' legitimate concerns about wellness programs. This analysis not only is relevant to employers, employees,

258 See Matt Lamkin, *Health Care Reform, Wellness Programs and the Erosion of Informed Consent*, 101 KY. L.J. 435 for an analogous discussion of the importance of informed consent in disease management programs.

courts, and regulators seeking a coherent and comprehensive interpretation of existing law, but also highlights certain complexities of wellness program regulation that ought to be accounted for in any future legislation designed to promote workplace wellness programs.