EMPLOYEE WELLNESS PROGRAMS: A CURE FOR EMPLOYER HEALTH PLANS?

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Abstract

Employers are increasingly implementing wellness programs to induce their employees to live healthier lifestyles in order to reduce escalating healthcare costs. Congress is currently considering legislation that would offer employers tax credit for implementing wellness programs.[1] Employers, however, are confused as to what incentives they can lawfully implement because of recent lawsuits such as the program involving The Scotts Company's mandatory smoking cessation program.

Little caselaw exists in the area of employee wellness programs and the test cases are a long time away from appellate resolution. An anticipatory analysis of wellness program jurisprudence and regulation is crucial for employers to make reasoned decisions about their own implementation of cost-saving wellness programs, so that their programs will withstand legal scrutiny. This Note will examine the legal vulnerabilities of mandatory and voluntary employee wellness programs and make the case for legislative and judicial acceptance due to the growing importance of these programs in the entrepreneurial business setting.

I. WHY WELLNESS PROGRAMS?

Nationally, U.S. healthcare costs are steadily rising. In 1996, the average healthcare expense per person in the U.S. was $2,398[2] and aggregate U.S. expenses on healthcare totaled $554 billion.[3] Comparatively, the average healthcare expense per person in the U.S. in

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* J.D., The Ohio State University Michael E. Moritz College of Law, expected May 2009. Special thanks to Susan Ghandakly, Adel Ghandakly, and Dave Knapp.

[1] Wellness and Prevention Act of 2007, H.R. 853, 110th Cong. (2007), currently under consideration by the House Subcommittee on Health.

[2] Joel W. Cohen et al., Healthcare Expenses in the United States, 1996: MEPS Research Findings, U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, AHRQ Pub. No. 01-0009, December 2000, 1.

[3] *Id.* at 9.

2004 was $3,879[4] and aggregate expenses totaled $963.9 billion.[5] With an over 60% increase in per capita healthcare expenses in less than a decade, companies are desperately seeking ways to keep the costs of their employee healthcare programs down. Some studies even indicate that growth in healthcare benefit costs in U.S. corporations may overtake profits within a decade.[6]

The increase in health care expenses may explain why the number of small firms offering employer-sponsored health coverage has dropped 12% since 2000.[7] But rather than simply drop coverage, more employers are seeking creative solutions to the healthcare dilemma, and employee wellness programs offering lower premiums for healthier lifestyles have arisen as the premier solution. Placing the responsibility of unhealthy lifestyle choices on employees by offering lower premiums as an incentive for healthier lifestyles should decrease employer healthcare costs in the long run.

Studies indicate that the annual savings produced by wellness programs are around $613 per participant.[8] A report issued by the U.S. Department of Health and Human Services estimated that 75% of U.S. healthcare dollars are spent on chronic conditions, most of which are preventable,[9] and that roughly 14%--more than $20 billion—of Medicaid expenses are for smoking-related illnesses.[10]

The Center for Disease Control ("CDC") estimates that smoking-attributable healthcare expenditures and associated productivity losses cost the United States over $167 billion per year from 1997-2001.[11] For

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[4] Steven R. Machlin & Kelly Carper, National Healthcare Expenses in the U.S. Civilian Noninstitutionalized Population, 2004. Statistical Brief #149. Nov 2006. Agency for Healthcare Research and Quality at 1. This number is $3221.89 in 1996 dollars, as adjusted for inflation through the U.S. Department of Labor Bureau of Labor Statistics Consumer Price Index.

[5] *Id.* This number is $800.6 billion in 1996 dollars, as adjusted for inflation through the U.S. Department of Labor Bureau of Labor Statistics Consumer Price Index at 1.

[6] "Will Healthcare Benefit Costs Eclipse Profits?" THE MCKINSEY QUARTERLY, September 2004, *available at* http://www.mckinseyquarterly.com/newsletters/chartfocus/2004_09.htm (last visited September 24, 2008).

[7] EMPLOYER HEALTH BENEFITS 2007 SUMMARY OF FINDINGS, THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, 4, *available at* http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf.

[8] *Wellness Programs Are Worth Every Dollar You Spend*, ST. LOUIS BUS. J., Mar. 31, 2007 at 10.

[9] *Id.*

[10] X. Zhang et al., *Cost of Smoking to the Medicare Program, 1993*, HEALTH CARE FINANCING REVIEW, Summer, 1999 at 16.

[11] Center for Disease Control, *Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 1997-2001.* 294 JAMA 7:788, August 2005 at 789; The CDC Calculates Smoking Attributable Fractions (SAFs) of health expenditures by state, based on the 1998 medical expenditure records

example, the CDC estimates that Ohio loses about $8.1 billion annually from smoking-attributable health expenditures and productivity losses.[12] Smoking is not the only targeted-wellness culprit. One study of obesity-attributable medical expenditures concludes that the United States spends about $75 billion annually on medical costs resulting from obesity.[13] While that study calculates only the direct medical costs of obesity, the indirect costs, including the value of lost profits from illness-related absence, lower productivity, and premature death could bring that total to $117 billion annually ($61 billion direct and $56 billion indirect).[14]

As more businesses realize the possibilities of this solution and implement mandatory wellness programs, however, employees are looking to the judicial system to keep their employers from what they view as regulation of their private lives.

II. THE CASE FOR WELLNESS PROGRAMS: A COST-BENEFIT ANALYSIS

Upon recognizing the serious economic impact of employee health risk factors on business profits, the question then becomes whether the relatively small incentive-based savings that wellness programs can offer will really make a difference. A recent study by the Milken Institute uses the 2003 Medical Expenditure Panel Survey ("MEPS") data to analyze the impact of the seven most common chronic diseases—cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions, and mental disorders.[15] The authors model a scenario based on current data against a scenario assuming reasonably optimistic changes in health behavior and treatment—specifically, that overweight and obesity numbers

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from the Centers for Medicare and Medicaid Services (CMS) and on 2001 smoking prevalence data from the Behavioral Risk Factor Surveillance System (BRFSS). SAFs for each disease are calculated by using the following equation: $SAF = [(p_1(RR_1 - (1) + p_2(RR_2 - 1)] / [p_1(RR_1 - (1) + p_2(RR_2 - (1) + 1]$ where p_1 = percentage of current smokers (persons who have smoked ≥100 cigarettes and now smoke every day or some days), p_2 = percentage of former smokers (persons who have smoked ≥100 cigarettes and do not currently smoke), RR_1 = relative risk for current smokers relative to never smokers, and RR_2 = relative risk for former smokers relative to never smokers.

[12] *Id.*

[13] E.A. Finkelstein, *State-Level Estimates of Annual Medical Expenditures Attributable to Obesity*, OBESITY: A RESEARCH JOURNAL, 2004, 12, no. 1, 18 at 24; calculated in 2003 dollars.

[14] A. Wolf & G. Colditz, *Current Estimates of the Economic Cost of Obesity in the United States,* OBESITY: A RESEARCH JOURNAL, 2006, 6, no. 2, 97 at 106.

[15] Ross DeVol et al., *An Unhealthy America: The Economic Burden of Chronic Disease—Charting a New Course to Save Lives and Increase Productivity and Economic Growth*, Milken Institute October 2007 at 1. State-by-state data, available at http://www.chronicdiseaseimpact.com (last visited September 24, 2008).

return to their 1998 levels of 32.2% and 19% respectively by the year 2023, smoking declines at a slightly faster rate than the previous two decades to reach about 15 % by 2023, and there are modest improvements in early intervention treatment for chronic illnesses.[16] The study demonstrates that reasonable improvements in prevention and wellness incentives would cut direct treatment costs in 2023 by $217 billion, with cumulative savings from now through 2023 totaling $1.6 trillion.[17]

A final calculation in the cost-benefit assessment of a potential wellness program must involve return on investment ("ROI"). That too is persuasive. A recent study on worksite health promotion programs found an average return on investment of $3.14 per $1.00 invested in employee health, with ROIs of individual programs ranging from $1.49 to $13.00.[18] A study by Larry Chapman, a meta-evaluation of worksite health promotion economic return studies, rated the strength of methodology of fifty-six peer-reviewed studies on worksite health promotion programs.[19] Based on the strongest studies, the meta-evaluation concludes that wellness programs produce an average net savings of 26% of costs associated with health treatment, 27% of costs associated with sick-leave absenteeism, and 32% of costs associated with workers' compensation and disability management claims.[20] The overall ROI in the Chapman meta-evaluation was $5.81 saved for every $1.00 spent on worksite health promotion, with reductions materializing within an average period of 3.6 years.[21] Thus, a cost-benefit analysis of implementing employee wellness programs produces net gains that accrue rather quickly to businesses.

III. MANDATORY PROGRAMS AND THE SCOTTS COMPANY CASE

The first employee wellness program to come under judicial scrutiny—and, thus, national awareness—was The Scotts Company's ("Scotts") mandatory smoker cessation policy. A 42% increase in Scotts' healthcare costs from 1999 to 2003 led the company to adopt one of the

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[16] Devol et al., *supra* note 15 at 3.
[17] *Id.* at 8.
[18] S.G. Mitchell et al., *The Value of Worksite Health Promotion,* ACSM's Health & Fitness Journal, 12 (2), 23 at 27, 2008.
[19] Larry S. Chapman, *The Art of Health Promotion - Meta-evaluation of Worksite Health Promotion Economic Return Studies: 2005 Update*, AJHP: American Journal of Health Promotion, 19, no. 6 at 1, 2005.
[20] *Id.* at 6.
[21] *Id.*

strictest mandatory employee wellness programs in the nation.[22] Employees who opt into taking a monthly health risk assessment are rewarded with a $40 monthly decrease in their health insurance premiums while those who do not comply with their individually assigned health action plans face a $67 monthly increase.[23]

On October 1, 2006, Scotts launched the mandatory component of its wellness program—it went tobacco-free.[24] A month later, a newly hired employee, Scott Rodrigues, was fired before he had finished his year-long probationary employment period because he failed a nicotine test.[25] This led to his pending lawsuit, alleging violations of the Employee Retirement Income Security Act ("ERISA") § 510 and seeking to enjoin Scotts' mandatory anti-nicotine program.[26] On January 30, 2008, a Massachusetts federal district court declined Scotts' motion to dismiss on the ERISA § 510 claim, stating that,

> The ultimate inquiry in a section 510 case is whether the employment action was taken with the specific intent of interfering with the employee's ERISA benefits.... Two related points deserve notice. First, section 510 does not apply to those instances where 'the loss of benefits was a mere consequence, but not a motivating factor behind, a termination of employment.'... And second, section 510 'relates to discriminatory conduct directed against individuals, not to actions involving the plan in general.'... The resolution of each of these issues may depend on what facts the plaintiff may ultimately prove. Scotts' expectation that the facts ultimately proved (or not proved) will resolve the issues in its favor is not enough to warrant dismissal on a Rule 12(b)(6) motion.[27]

Rodrigues' essential claim is that although he does not yet have a health problem, Scotts is denying him benefits based on behavior that the company believes will lead to an expensive health issue[28]. Because, as the court said, the resolution of such cases is very dependant on the facts of each case, close attention must be paid to the details of any employee

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[22] Michelle Conlin, *Get Healthy—Or Else; Inside One Company's All-Out Attack on Medical Costs.* BUSINESSWEEK Vol. 4023, Page 58, February 26, 2007, at 3.
[23] *Id.* at 4.
[24] *Id.* at 2.
[25] *Id.*
[26] Rodrigues v. The Scotts Company, LLC, Amended Complaint and Jury Trial Demand, C.A. 07-10104-GAO, (Mass. Dist.), Filed 1/24/2007, 7-8.
[27] Rodrigues v. Scotts Co., LLC, 07-10104 (D. Mass. Jan. 30, 2008); Slip Copy, 2008 WL 251971 (D.Mass).
[28] Jill Schachner Chanen, *The Boss is Watching*, ABA JOURNAL, January 2008, http://abajournal.com/magazine/the_boss_is_watching/ (last visited Sept 24, 2008).

wellness program. This case will be the first to indicate how the courts will treat mandatory employee wellness programs in the future and give employers an idea of how much litigation risk exists because of the implementation of these programs.

IV. LEGAL PARAMETERS OF EMPLOYMENT PROGRAMS

On the voluntary end of the wellness program continuum, employers offer incentives like discounts on health insurance premiums, subsidized gym memberships, and voluntary smoking cessation and weight loss programs. Legal issues arise when employers start to require certain health standards or behavior changes as conditions to employment or penalize non-participants. Specifically ERISA[29], the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")[30], and the Americans with Disabilities Act ("ADA")[31] are potential legal hurdles to any wellness program. Employers seeking to implement legitimate wellness programs must cautiously assess the legal issues that these regulations pose.

A. *ERISA § 510*

Under ERISA § 510, an employer may not terminate an employee specifically to prevent that employee from obtaining his or her benefit rights.[32] Explicitly, ERISA makes it illegal for any person to "discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan" or "for the purpose of interfering with the attainment of any right to which such participant may become entitled."[33] Thus, ERISA §510 is where the contours of a mandatory wellness program will undergo the closest legal analysis and the statute under which most lawsuits of this type will likely be brought.

Under ERISA, employees must be "plan participants" in order to have standing to file a lawsuit.[34] To establish a prima facie case under

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[29] Employee Retirement Income Security Act § 510, 29 U.S.C. § 1140 (2008).
[30] Health Insurance Portability and Accountability Act, 26 C.F.R. 54.9802-1 (2008).
[31] Americans with Disabilities Act, 42 USC §12112 (2008).
[32] ERISA § 510, *supra* note 29; *See e.g.,* Lessard v. Applied Risk Management, 307 F.3d 1020, 1024, (9th Cir. 2002) (company reorganization that caused plaintiff to lose benefits violated ERISA) and Gavlik v. Continental Can Co., 812 F.2d 834, 838, (3d Cir. 1987) (liability avoidance procedure that red-flagged employees about to become eligible for severance found to violate ERISA).
[33] ERISA § 510, *supra* note 29.
[34] *See* Alexander v. Electronic Data Systems Corp., 13 F.3d 940, 947 (6th Cir. 1994); "participant" is defined as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit

ERISA §510, a plaintiff must show (1) that an employer took specific actions (2) for the purpose of interfering (3) with an employee's attainment of pension benefit rights.[35] Then, the burden shifts to the employer to articulate a "legitimate nondiscriminatory reason" for their conduct.[36] Once articulated, the burden shifts back to the plaintiff to show that "the employer's rationale was pre-textual and that the cancellation of benefits was the 'determinative influence' on the employer's actions."[37] For example, employees fired "for cause" have brought successful ERISA claims by showing a compelling link between the time of their firing and an upcoming ability to participate in a severance plan.[38]

Therefore, when an employer fires an employee who refuses to do the mandatory exercise, health, or smoking regimen outlined in a wellness program, there is the potential for ERISA § 510 litigation. Voluntary wellness programs, however, where employers offer access to gyms and dieticians to encourage healthy lifestyles, are probably acceptable under ERISA. But, programs that impose punitive costs or even discharge for failure to reach certain health requirements (like target cholesterol, body mass index, or blood pressure levels) arguably allow employers to take "discriminatory" action that prevents employees from receiving health benefits.

The employee's discrimination claim will fail, however, if the employer can articulate a legitimate, non-discriminatory, non-pretextual reason for the adverse action. The heart of the issue, then, lies in divining whether a broad wellness *program* can be discriminatory to any single employee who is fired. That would require the specific intent to deprive the individual employee of medical benefits under the group health plan. Indeed, "no ERISA cause of action will lie where the loss of benefits was a mere consequence of, but not a motivating factor behind, a termination of employment."[39] Additionally, the Supreme Court has held that, although employee welfare benefit plans are subject to ERISA § 510, an employer acting without intent to interfere with an employee's right, as when making fundamental business decisions, is not barred by § 510.[40] Furthermore, employers may design or amend benefit plans in ways that favor certain employees over others so long as they do not "reduce participants' vested interests."[41]

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plan which covers employees of such employer . . . ." ERISA, 29 U.S.C. § 1002(7) (2008).

[35] Eichorn v. AT&T Corp., 248 F.3d 131, 149 (3d Cir. 2001).

[36] *Id.*

[37] *Id.*

[38] Leszczuk v. Lucent Technologies, Inc., Civil Action No. 03-CV-00000576, slip op., at *3 (E.D. Penn. June 10, 2005).

[39] Dister v. Continental Group, Inc., 859 F.2d 1108, 1111 (2d Cir. 1988).

[40] Inter-Modal Rail Employees Ass'n. v. Atchison, Topeka, and Santa Fe Ry. Co., 520 U.S. 510, 510 (1997); *Curtiss-Wright v. Schoonejongen, 115 S.Ct. 1223*, 1226 (1995).

[41] Coomer v. Bethesda Hosp., Inc., 370 F.3d 499, 509 (6th Cir. 2004).

A legitimate wellness program implemented by an employer, even for the purpose of decreasing overall company healthcare costs is a fundamental business decision on the part of the employer. Thus, a logical and compelling argument exists that adverse action taken toward an employee in furtherance of such a program lacks the specific discriminatory intent required for an ERISA violation. That said, the matter is far from settled (given the pending Scotts case on the matter). The question for the employer, then, is a personal cost-benefit analysis of whether the cost of potential litigation now is worth the healthcare savings in the long run.

B. *HIPAA*

In 1996, HIPAA amended ERISA to provide new rights and protections for participants in group health plans. HIPAA prohibits ERISA group health plans from charging participants different premiums "based on a health factor."[42] The enumerated list of "health factors" includes health status, medical conditions (including physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including things like conditions arising from acts of domestic violence or participation in activities like motorcycling and skiing), and disability.[43] This poses serious questions as to certain wellness programs because the statute itself states that a requirement to pass a physical examination in order to enroll in an employee health plan would discriminate based on a health factor, thus violating the Act.[44] It follows that requirements based on nicotine addiction or weight could be considered discrimination based on a health factor.

Group health plans cannot charge "similarly situated" health plan participants different premiums based on any health factor.[45] However, on December 13, 2006, the Employee Benefits Security Administration ("EBSA"), along with the Department of Labor and the Internal Revenue Service ("IRS"), added a wellness-program exception to apply to any plan year beginning on or after July 1, 2007.[46] An employee wellness program is compliant with HIPAA's nondiscrimination requirements if: (1) participation in the program is made available to all similarly situated individuals;[47] and (2) no reward is offered, or no conditions for obtaining offered rewards are based on an individual satisfying a specific health standard related to a health factor.[48] Wellness programs that do condition

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[42] "Prohibiting discrimination against participants and beneficiaries based on a health factor" 26 C.F.R. 54.9802-1, December 13, 2006.
[43] *Id.*
[44] *Id.* Ex. 1.
[45] *Id.*
[46] *Id.*
[47] *Id.* at (f)(1).
[48] Factors relating to prohibiting discrimination, *supra* note 42, at (f)(1).

rewards on individuals satisfying specific health standards must meet the following five requirements:[49]

1. The total reward that can be given to an individual cannot exceed 20% of the total cost of employee-only coverage under the plan. If dependents may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled;
2. The program must be reasonably designed to promote health and prevent disease;
3. The program must give eligible individuals the opportunity to qualify for the reward at least once per year;
4. The reward must be available to all similarly situated individuals and the program must allow a reasonable alternative standard, or waiver of the initial standard, for obtaining the award to any individual for whom it is "unreasonably difficult due to a medical condition, or medically inadvisable," to satisfy the condition; and
5. All plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard or the possibility of waiver of the applicable standard. If the alternative is unreasonable, the employee is given the same discount if he attains a reasonable alternative standard tailored to the individual's situation

Therefore, incentives conditioned on program participation rather than health factor results will be compliant with HIPAA.[50] Such programs may include gym membership fee reimbursement, rewards for attending monthly health seminars, incentives to participate in cholesterol or blood-pressure screening (if paid for and regardless of outcome), and reimbursement for weight-loss and smoking cessation programs (if paid for and regardless of outcome). Programs like premium reductions conditioned on reaching target cholesterol/BMI numbers or on quitting smoking, however, must meet the five reward-based factors.[51] For those, importantly, the plan materials describing the program should make the required reasonable alternative standard known and the employer should express willingness to work with the employee and his or her physician to develop another way to have the deductible waived or decreased.[52]

Differential treatment based on addiction poses a more slippery question. To offer a group health plan with a smoker/non-smoker-based premium differential, for example, is to condition a reward on satisfying specific health standards (i.e. not smoking). Therefore, such a program

[49] *Id.* at (f)(2).
[50] *Id.* at (f)(1).
[51] *Id.* at (f)(2).
[52] *Id.* at (f)(3)(ex. 4).

would be allowed under HIPAA, but must meet the five aforementioned requirements for standard-based requirement programs.

Notably, though, HIPAA regulation of wellness programs may not be as straightforward as the newly tailored regulations might seem to indicate. There are gray areas that may leave even finely-tuned programs amenable to suit. Specifically, although voluntary participation in a health assessment seems facially nondiscriminatory, it may be challenged as discriminatory on the basis that employees who may need these health assessments the most will be afraid of what the assessments will reveal and, thus, less willing to participate for fear of embarrassment. This disparate impact approach to seemingly voluntary incentives may leave open the question of discriminatory availability of the premium reduction.

C. *ADA*

Under the ADA, an employer may not discriminate against a qualified individual with a disability with regard to, among other things, employee compensation and benefits available by virtue of employment.[53] Additionally, an employer's medical inquiries or examination of current employees regarding the nature, existence, or severity of a disability must be justified by job-relatedness and business necessity.[54] All employees are qualified for this protection, regardless of whether they are deemed to be "qualified individuals with a disability."[55] Thus, the ADA impacts mandatory wellness programs by: (1) limiting the circumstances under which an employer may ask questions about an employee's health or require the employee to have a medical examination, (2) imposing strict confidentiality requirements for disclosure of medical information, and (3) requiring alternatives for individuals who are able to perform the essential functions of their job but, because of disability, unable to achieve a health factor requirement under a mandatory wellness plan.[56]

The Equal Employment Opportunity Commission ("EEOC"), the implementing agency of the ADA, has taken the position that it is permissible to ask for medical information as part of a voluntary wellness program that focuses on early detection, screening, and management of disease.[57] However, to avoid the first two obstacles, the safest bet for employers is to retain an independent third party to administer the program by collecting all medical information and not disclosing individual health data to the employer (as Scotts did). The third obstacle, reasonable

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[53] "Equal Opportunity for Individuals with Disabilities" 42 USC §12112(a)-(b) (2008).
[54] *Id.* at (a), (d)(4)(a).
[55] *See e.g.* Fredenberg v. Contra Costa Co. Dept of Health Services, 172 F.3d 1176, 1182 (9th Cir. 1999), Conroy v. New York State Dept of Corr. Servs., 333 F.3d 88, 94 (2nd Cir. 2003).
[56] ADA, *supra* note 53, at (d)(4)(a).
[57] *Id.* at (a), (a)(d)(4)(a).

accommodations, will probably be overcome by satisfying the similar HIPAA requirement, although this has not yet been definitively concluded.

There is an argument that wellness programs do not discriminate on the basis of a disability because their terms apply equally to disabled and non-disabled employees.[58] However, an employer may not use risk-assessment activities as a subterfuge to evade the ADA's nondiscrimination requirements (e.g. refusing to hire disabled persons solely because their disabilities may increase the employers future healthcare costs; denying disabled employees equal access to health insurance based on disability alone if the disability poses no increased insurance risks).[59] Thus, this argument probably does not remove ADA scrutiny of wellness programs.

Specifically noting the benefits of employee wellness programs, the ADA exempted health programs as long as certain requirements are met.[60] Such requirements include the following (1) participation is voluntary, (2) any health information obtained remains confidential and separate from other employment records, and (3) the health information obtained is not be used to limit health insurance coverage eligibility or take adverse employment action.[61] The key question then becomes whether a program is voluntary.

A wellness program is voluntary as long as an employer "neither requires participation nor penalizes those employees who do not participate."[62] The focus on whether programs are to be considered "voluntary" is discussed in detail in other articles on the subject, but is an important consideration to discuss here.[63] Employers must remain attentive

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[58] *See e.g.* Krauel v. Iowa Methodist Med. Ctr., 915 F. Supp. 102, 102, (S.D. Iowa 1995) (health plan's exclusion for infertility treatments was not a distinction based on disability, because it applied to individuals who did and did not have disabilities); EEOC v. Staten Island Sav. Bank, 207 F.3d 144, 146, (2d Cir. 2000) (in the context of a long term disability plan, offering different benefits for mental and physical disabilities does not violate the ADA, because every employee was offered the same plan regardless of disability status).

[59] See e.g. 42 U.S.C. § 12201(c)(2); Barnes v. Benham Group, Inc., 22 F. Supp. 2d 1013, 1014, (D. Minn. 1998) (holding in favor of the employer on an ADA claim, where the employer terminated an employee who refused to complete a health insurance enrollment form, because the form was used by the insurer to classify or underwrite risk); McLaughlin v. General Am. Life Ins., 1998 U.S. Dist. LEXIS 16994 (E.D. La. Oct. 21, 1998) (preexisting condition limitation excluding payment of claims for which the insured had been treated during the last 12 months did not violate ADA).

[60] ADA, *supra* note 44 at § 102(c)(4)(B).

[61] 29 C.F.R. § 1630.14(d) app. 56 Fed. Reg. 35,726, 35,751 (1991); 42 U.S.C.A. § 12112(c)(4)(B) (2006), ADA § 102(c)(4)(B)

[62] Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA), *available at* www.eeoc.gov/policy/guidance.html (last visited Sept 24, 2008).

[63] Jon McLaughlin, *What Relevance Does the ADA Have to HIPAA-Regulated "Bona Fide Wellness Programs"?* IL. BUS. L. J. 2007;

to the distinction between an incentive and a requirement or penalty. While free gym memberships and access to dieticians remain purely voluntary, monetary incentives may straddle the voluntariness line, depending on how large the incentive or how steep the penalty.

A 1998 EEOC unofficial opinion letter on wellness programs states that "it could be argued that providing a monetary incentive to successfully participate renders the program involuntary because the size of the payment must be considered."[64] The 1998 letter was in response to an inquiry involving an employer's wellness program that offered a 20% insurance premium reduction for each of five criteria they meet, including not using tobacco products, exercising for a specific amount of time each week, and maintaining a certain weight, blood pressure, and cholesterol level.[65] The fact that the wellness program referred to in the letter would allow employees up to a 100% reduction in their insurance premium—and that the letter acceded "it could be argued that this satisfies the voluntary requirement of section 102(d)(4)(B)"—indicates that a program that simply offers a 20% reduction in an insurance premium (HIPAA's limit, anyway) would be acceptably voluntary.[66] Logically, a program that offers a premium reduction to participants, rather than a punitive increase to non-participants, seems voluntary. Even still, employers should be wary of offering base premium levels that are "too high" in hopes that employees will be more apt to need the participation-induced reductions.

Thus, a program that neither requires specific standards nor offers a punitive disparity in premiums should qualify under the ADA under its voluntariness exception. Mandating a specific result as a condition of employment, though, is a riskier endeavor. However, note that not all at-risk health conditions are tied to a disability. Excess weight may be tied to a sedentary lifestyle or poor diet and not necessarily to diabetes or an endocrine imbalance. Smoking, excessive drinking (short of alcoholism, which may be considered a disability), or recreational drug use (short of addiction) are poor health habits that are not *per se* protected by the ADA. Programs that do not deal with "disabilities"[67] need not worry about achieving the voluntariness requirement to the ADA exception and, thus,

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http://iblsjournal.typepad.com/illinois_business_law_soc/2007/02/hippa_wellness_.html (last visited Sept 24, 2008).

[64] Unpublished, unofficial opinion letter on file with author or can be acquired from the EEOC; at 1.

[65] *Id.* at 2

[66] *Id.* at 3

[67] The Supreme Court has ruled that the determination of whether a person has an ADA "disability" must take into consideration whether the person is substantially limited in performing a major life activity **when using a mitigating measure.** This means that if a person has little or no difficulty performing any major life activity because s/he uses a mitigating measure, then that person will not meet the ADA's first definition of "disability." Sutton v. United Airlines, Inc., 527 U.S. 471, 474 (1999); *also see* Murphy v. United Parcel Service, Inc., 527 U.S. 516, 518 (1999).

can mandate target health levels (subject to the requirements of other regulations) or require participation.

Finally, the disparate treatment/disparate impact issue touched on in the HIPAA section is a substantial consideration in ADA analysis of wellness programs. Specifically, employers should take care to tailor any health requirements differently to men and women because of genetic differences that place them on unequal footing. For example, rather than mandating specific cholesterol or BMI numbers as conditions for rewards, programs should define such goals by percentiles keyed to men, women, or different age groups in order to avoid disparate impact discrimination litigation.

D. *Other Relevant Statutes to Consider*

The Age Discrimination in Employment Act of 1967 ("ADEA") prohibits employers from making employment decisions, or otherwise discriminating against, individuals because of age.[68] If a mandatory wellness program requires that an employee achieve a certain health standard, it should be crafted to account for, and if necessary, adjust for the age of the employee. Here, the disparate impact claims could very well come into play so, again, close tailoring of wellness programs to differently situated employees is important.

Additionally, Title VII prohibits discrimination by covered employees on the basis of race, color, religion, sex, or national origin and may trigger wellness program problems for some protected classes.[69] If specific health standards are set, employers should be prepared to objectively demonstrate with appropriate expert data that the standards do not discriminate against women, as explained earlier. Similarly, with religion, employers should be aware that some individuals may refuse to take medication due to religion, but can still be asked to make "reasonable accommodations" in diet, exercise, and so on, even though they remain outside of the target health results. The key is to always disclose accommodations clearly and objectively to all employees.

V. PREEMPTION AND STATE LAWS REGARDING LAWFUL OFF-DUTY CONDUCT

The legality of mandatory wellness programs will vary from state to state, and any company considering implementing a mandatory program must pay careful attention to state statutory schemes regarding employer conduct. For example, so-called "smoker protection laws" remain on the

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[68] Age Discrimination in Employment Act, 29 U.S.C. §634 (2008).
[69] 42 U.S.C. § 2000e-2 [3]

books in 31 states and the District of Columbia.[70] Other states, like Colorado and New York, prohibit employers from taking adverse employment action for recreational activities and lawful off-duty conduct, like smoking or other high-risk activities (skydiving, for example).[71] Thus, in those states with "lifestyle discrimination laws," employers cannot implement any mandatory wellness programs that condition adverse employment action on employee non-participation or failure, though incentives would probably be allowed.

However, state-law claims that relate to benefits under group health benefit plans are generally preempted by ERISA. The Supreme Court has held that, in general, a state law relates to an ERISA plan for preemption purposes if it has a "connection with or reference to such a plan."[72] Thus, preemption would apply not because of the wellness program itself, but because the wellness program is provided under a "group health benefits plan," which subjects it to ERISA.[73] For example, where an employer charging higher premiums to smokers under a group health benefit plan violates a state smoker protection statute, ERISA would preempt.[74] Alternatively, ERISA would not preempt a state law claim with only incidental effects on benefits.[75] In the end, an employer must examine state laws beyond the federal regulations discussed above to come up with a wellness program that will avoid litigation.

VI. ON THE HORIZON: THE FUTURE OF WELLNESS PROGRAMS

In recognition that widespread employee wellness programs are an inevitable result of the growing costs of company health care, legislation has emerged in both the federal and state settings. On the federal level, Congress is currently considering legislation that would offer employers tax credit for implementing wellness programs.[76] In current form, the bill would give tax credit if the follow criteria are met:[77]

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[70] Amanda E. Layton & Vjera V. Silbert, *Employers Considering Wellness Programs are Advised to Look Before Leaping,* WOLFBLOCK, November 2007.

[71] For example, Colorado prohibits firing employees on the basis of lawful off-duty conduct, but not other adverse employment sanctions less than firing. C.R.S. § 24-34-402.5 (2008). In one Colorado case, the court rejected a claim that a termination based upon the publication in a local paper of an employee's letter critical of the employer was unlawful, finding that the employee's actions were in breach of his duty of loyalty to the company.

[72] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 88, (1983).

[73] *Id.*

[74] Francis P. Alvarez & Michael J. Soltis, *Preventative Medicine: Employee Wellness Programs are Prone to Legal Maladies that Require Careful Monitoring,* HR MAGAZINE, Jan 2006 at 11.

[75] *Id.*

[76] Wellness and Prevention Act of 2007, *supra* note 1.

[77] *Id.*

1. The program is implemented with consultation with someone who has implemented a wellness program before and will ensure compliance with appropriate measures to protect participant privacy (like Scotts' third party implementer);
2. Health-risk assessments are conducted for each participant;
3. At least two of the preventative services recommended by the U.S. Preventative Task Force are implemented on an annual basis;
4. The employer offers annual counseling sessions and seminars related to at least three of the following: smoking, obesity, stress management, physical fitness, nutrition, substance abuse, depression, mental health, heart disease, and maternal/infant health;
5. At least 50% of eligible full-time employees participate in the program.

Additionally, many states have passed legislation on issues driven by the emergence of private employee wellness programs. Michigan has recently added weight as a protected class for purposes of discrimination.[78] Washington is considering legislation that would make it illegal for an employer to require an employee to disclose information about tobacco usage or to ask employees not to consume lawful tobacco products during non-working hours.[79] Again, such statutes must be researched when implementing any wellness program in a state, and due care should be paid to the above considerations of when ERISA will preempt state laws.

On the other end of the spectrum, several state legislatures are considering tax incentive legislation similar to the potential federal incentives.[80] Additionally, states like Ohio are starting to adopt their own public-employee wellness programs.[81] Ohio has put together a $10 million "Take Charge, Live Well" program to incentivize health assessments and

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[78] Mich LA § 37.2207 (2008). Similarly, Massachusetts is considering adding both height and weight as protected classes, (H.R. 1844, 185th Gen. Crt., Reg. Sess. (Mass. 2007).

[79] H.R. 1154, 2007 Leg., Reg. Sess. (Wash. 2007). The legislation would, however, allow employers to do these things under the terms of the employers insurance policy.

[80] California (A. 1439, 2007 Leg., Reg. Sess. (Cal. 2007); Florida (H. 325, 2007 Leg., Reg. Sess. (Fla. 2007); S. 194, 2007 Leg., Reg. Sess. (Fla. 2007); Indiana (H. 1008, 115th Gen. Assem. 1st Reg. Sess. (Ind. 2007), H. 1083, 115th Gen. Assem. 1st Reg. Sess. (Ind. 2007); New Jersey (A. 990, 212th Leg., 2006 Sess. (N.J. 2007); S. 527, 212th Leg., 2006 Sess. (N.J. 2007); New York, (S. 2595, 2007–2008 Leg., Reg. Sess. (N.Y. 2007); Arizona (S. 1098, 48th Leg., 1st Reg. Sess. (Ariz. 2007); Wisconsin (S.R. 3, 2007 Leg., Reg. Sess. (Wis. 2007); and Texas (S. 72, 80th Leg., Reg. Sess. (Tex. 2007), S. 556, 80th Leg., Reg. Sess. (Tex. 2007).

[81] Alan Johnson, *Cashing in on Healthful Lifestyles,* THE COLUMBUS DISPATCH, Jan 17, 2008 at A2

screenings as well as exercise and stress-reduction programs.[82] The state estimates that 44% of its healthcare bill is made up of preventable conditions and expects a $35 million annual return on healthcare costs after the program has been in place for a few years.[83]

VII. CONCLUSION

As healthcare costs rise and businesses of all size develop creative solutions to those costs, America's employment laws must maintain a balance of employee protection and employer freedom. Now is a moment when innovative solutions to employer-based healthcare programs are crucial to staying profitable while keeping employees healthy. Unfortunately, now is also a moment of uncertainty in the legal area of the most innovative of such solutions—incentive-based wellness programs. Before it becomes clear how the courts will treat these programs and employer actions, businesses must balance the risk of litigation and narrowly tailor their programs to fit within the aforementioned regulations. After accounting for any off-duty conduct statutes in the state of a proposed wellness program, an entrepreneurial business should bear in mind the following criteria when creating their cost-saving plan:

- To err on the side of safety, if cost allows, a third party administrator for a wellness program is advised in order to avoid potential confidentiality issues;
- Basic voluntary wellness programs, such as offering free gym memberships, access to dietary advisors, company smoker cessation help programs, and the like are almost certainly legal;
- Any adverse employment action taken (discharge or otherwise) should be taken as part of an across-the-board policy so as to lessen any potential claim for specific discrimination under ERISA;
- Participation in any wellness program must be made available to all similarly situated employees;
- If rewards (such as premium reductions) are conditioned on achieving specified health standards, it cannot exceed 20% of coverage, the program must give eligible employees the opportunity to qualify at least once per year, be reasonably designed to promote health, and be offered to all similarly situated individuals, with a clearly laid out option of reasonable accommodations for those who cannot achieve such goals;
- Disparate impacts of target health standards must be accounted for in any mandatory program, so target levels are better off tailored

[82] *Id.*
[83] *Id.*

with respect to gender/age/religious requirements, rather than universal number requirements.

In the end, health and legal concerns always involve the balancing of risk. In the uncharted waters of employee wellness programs, individual employers will need to decide whether their long-term reduced healthcare costs will outweigh the potential and short-term threat of litigation. Likewise, the U.S. will have to decide where to draw the line between what constitutes an acceptable business decision and what is too private for employers to control.

Author's note: This note should not be understood as legal advice, but is rather the author's analysis of current law on the matter. You are not advised to rely on the information given for the purposes of litigation.