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Submitted to the United States Senate Committee on Health, Education, Labor and Pensions

Hearing on "Employer Wellness Programs: Better Health Outcomes and Lower Costs"

January 29, 2015

Chairman Alexander, Ranking Member Murray, Members of the Committee, my name is Judith Lichtman, and I am Senior Advisor at the National Partnership for Women & Families. Thank you for the opportunity to offer recommendations on ensuring nondiscrimination in employer wellness programs, to be considered today in conjunction with the committee's hearing.

The National Partnership is a non-profit, nonpartisan advocacy organization with more than 40 years of experience promoting fairness in the workplace, access to quality health care and policies that help women and men meet the competing demands of work and family. Since our creation as the Women's Legal Defense Fund in 1971, we have fought for every significant advance for equal opportunity in the workplace, and we continue to advocate for meaningful safeguards that prevent discrimination against women and families.

I. Ensuring Nondiscrimination in Wellness Programs Requires Careful Analysis

The National Partnership represents women and families across the country. As health care purchasers, consumers and decision makers for themselves and their families, women are keenly interested in wellness and prevention of illness. Employer wellness programs – if designed and implemented properly – can potentially offer women and their families an avenue for improving and maintaining their health, and lower costs for the employer.[1]

A well-designed, voluntary wellness program should be individually tailored and focused on the health and well-being of each employee. Employers should take into account personal circumstances, including family caregiving responsibilities or multiple jobs, that may make it difficult for employees, particularly women, to participate in wellness programs that take place outside of normal work hours. Employers should look to accredited wellness programs as guides. These programs offer true benefits that can help women achieve their wellness goals by

[1] Mercedes Carnethon, et al., Worksite wellness programs for cardiovascular disease prevention: a policy statement from the American Heart Association. American Heart Association Advocacy Coordinating Committee; Council on Epidemiology and Prevention; Council on the Kidney in Cardiovascular Disease; and Council on Nutrition, Physical Activity and Metabolism (2009).

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providing activities at a time and location that fits the time constraints associated with their obligations at home and in the workplace. While there may be benefits of "participatory" wellness programs that seek to improve employee health across the board, we continue to be concerned by outcomes-based or punitive wellness programs that operate to shift costs to employees and have not been scientifically proven to promote improved health.

There is scant evidence showing that punitive programs tying health insurance premiums to health outcomes actually improve employee health.[2] These wellness programs often require a one-size-fits-all approach that does not address individual employees' life circumstances and wellness needs; these programs often utilize biometrics that are not always adequate measures of health. Such programs enable employers to reduce their health care costs under the guise of wellness promotion by merely shifting those costs to employees that they deem to be most unhealthy. This practice is akin to medical underwriting, the practice of determining an employee's health insurance premium on the basis of certain health information.[3] Employers must not be permitted to utilize employer wellness programs as a subterfuge for discriminatory cost-shifting that decreases affordability and access to health insurance for those who need it most.

As described in further detail below, punitive wellness programs implicate employment nondiscrimination statutes if they disproportionately penalize women, racial minorities, older workers and other protected classes. Wellness programs that impose punitive measures or that grant so-called "rewards" in the form of lower insurance premiums to some employees but not to others could run afoul of anti-discrimination laws if they have a disparate impact on members of a protected group. Women, racial minorities and older workers are more likely to pay increased costs associated with punitive wellness programs. These groups are more likely to experience significant health disparities and are particularly vulnerable to chronic illnesses, and as a result they may face greater difficulty satisfying employer-defined benchmarks.[4]

Although the Patient Protection and Affordable Care Act (ACA) permits employers to implement wellness programs, it also sets important nondiscrimination standards for such programs that are intended to safeguard civil rights. Section 1557 of the ACA prohibits discrimination on the basis of sex, race, color, national origin and disability by health programs receiving federal funds or by any entity established under Title I of the Act.[5] Section 1557 incorporates and applies numerous civil rights laws, such as Title VI of the Civil Rights Act of

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[2] *See* V. Paul-Ebhohimhen & A. Avenell, *Systematic review of the use of financial incentives in treatments for obesity and overweight*, 9 Obesity Reviews 355-67 (Oct. 23, 2007); Kevin G. Volpp, David A. Asch, Robert Galvin & George Loewenstein, *Redesigning Employee Health Incentives – Lessons from Behavioral Economics*, 365 N. Engl. J. Med. 388-390 (Aug. 4, 2011).

[3] Nat'l Women's Law Center, Nowhere to Turn: How the Individual Health Insurance Market Fails Women 7 (2008), http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf.

[4] Alina Salganicoff, et al., Women and Health Care: A National Profile, Kaiser Family Foundation (July 2005), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey.pdf; Leandris C. Liburd, *Looking Through a Glass, Darkly: Eliminating Health Disparities*, 3 Preventing Chronic Disease (July 2006), available at: http://www.cdc.gov/pcd/issues/2006/jul/pdf/05_0209.pdf.

[5] 42 U.S.C. § 18116.

1964,[6] Title IX of the Education Amendments of 1972,[7] the Age Discrimination Act of 1975,[8] and Section 504 of the Rehabilitation Act of 1973,[9] to federal health programs and entities. Section 1557's incorporation of these key protections mandates that health plans receiving federal premium tax credits are bound by existing civil rights law applicable to other federally assisted programs.[10]

Additional provisions of the ACA require insurance companies to cover all applicants and to offer enrollees the same rates regardless of pre-existing conditions or sex.[11] For example, the law prohibits gender rating.[12] The law also limits medical underwriting.[13] Allowing employer wellness programs to raise costs for protected groups contravenes the purpose of these provisions, which endeavor to ensure equal and affordable access to everyone, regardless of sex, pre-existing conditions, or other status.

Similarly, punitive programs that impose fees or withhold financial rewards for failing to meet certain health benchmarks carry the risk of disproportionately impacting groups protected under Title VII of the Civil Rights Act of 1964,[14] the Americans with Disability Act (ADA),[15] Age Discrimination in Employment Act (ADEA),[16] the Equal Pay Act,[17] Genetic Information Nondiscrimination Act,[18] and the Health Insurance Portability and Accountability Act (HIPAA),[19] among other laws. These laws prohibit discrimination on the basis of sex, race, national origin, age and other protected categories.

The Equal Employment Opportunity Commission (EEOC) is charged with ensuring that employer wellness programs do not operate as a subterfuge for unlawful discrimination. The EEOC, which is tasked with enforcing employment nondiscrimination laws, serves a critically important role in ensuring equal opportunity for workers in the United States. The EEOC is the first place workers who have experienced discrimination must go to pursue their claims and it provides invaluable assistance to workers in filing charges, investigating claims and mediating and attempting to conciliate the charges that the agency deems meritorious. The agency also litigates specific charges, authorizes workers to file complaints in court and participates as amicus curiae in key courts of appeals cases. Through enforcement, guidance, outreach, education, technical assistance and advice to other federal agencies, the EEOC has an opportunity to ensure that employers comply with nondiscrimination laws, such as those set forth

[6] 42 U.S.C. §§ 2000d *et seq*.
[7] 20 U.S.C. §§ 1681 *et seq*.
[8] 42 U.S.C. §§ 6101 *et seq*.
[9] 29 U.S.C. §§ 794 *et seq*.
[10] Rene Bowser, *The Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice*, 10 Hastings Race & Poverty L. J. 69, 91 (2013).
[11] 42 U.S.C. § 300gg.
[12] *Id*.
[13] 42 U.S.C. §§ 300gg-4(a) to (b).
[14] 42 U.S.C. §§ 2000e *et seq*.
[15] 42 U.S.C. §§ 12101-12213.
[16] 29 U.S.C. §§ 621-634.
[17] 29 U.S.C. § 206(D) (2006).
[18] 42 U.S.C. § 2000ff-6(a)(1).
[19] 42 U.S.C. §§ 300g, 1181 *et seq.*, 1320d *et seq.*

in the ACA and in other civil rights statutes, and follow best practices in the design and implementation of wellness programs.

II. Statutes Implicated in Nondiscrimination Analysis

A. Title VII of the Civil Rights Act of 1964: Employer wellness programs that impose disproportionate penalties or disproportionately deny rewards on the basis of sex, race or national origin may violate Title VII of the Civil Rights Act of 1964.[20]

Title VII prohibits discrimination with respect to "compensation, terms, conditions, or privileges of employment."[21] An employer may violate Title VII by treating members of a protected class differently than others (i.e., disparate treatment discrimination).[22] In order to state a disparate treatment claim, the plaintiff must show that the employer treats some people less favorably than others on the basis of plaintiff's membership in a protected group.[23] Critical to a disparate *treatment* claim is the employer's discriminatory motive, although this motive can be inferred in some circumstances.[24]

An employer may also violate Title VII by utilizing a facially neutral employment practice if it has an adverse *impact* upon persons of a protected group (i.e., disparate impact discrimination).[25] In order to state a prima facie disparate impact claim, the plaintiff must point to a specific policy or practice that has an adverse impact on the basis of race, sex, or other protected characteristics.[26] The Supreme Court, in a case addressing an employer's unequal provision of health insurance coverage, held that "health insurance and other fringe benefits are compensation, terms, conditions, or privileges of employment" under Title VII.[27] Charging increased fees or denying rewards for failure to meet certain biometrics could be subject to a disparate impact challenge under the Title VII framework.

For the purposes of an adverse action under a Title VII framework, financial rewards and penalties can operate as flip sides of the same coin. A wellness program that offers a "reward" to those who meet certain benchmarks may constitute an adverse action for those who do not qualify for the reward, just in the same way that a penalty may constitute an adverse action for those who are required to pay a higher cost. Although the language of the wellness program might refer to a "penalty" or "reward," the effect is the same: to shift the employer's health insurance costs disproportionately to protected groups.

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[20] 42 U.S.C. §§ 2000e *et seq*.
[21] 42 U.S.C. § 2000e-2(a)(1).
[22] *See, e.g., Dep't of Water & Power v. Manhart*, 435 U.S. 702, 711 (1978) (holding that the plaintiffs established a prima facie case of discrimination by demonstrating that an employer charged all female employees higher retirement fund premiums than it charged to males).
[23] *Id.*
[24] *Int'l Bhd. of Teamsters v. United States*, 431 U.S. 324, 335 n. 15 (1977).
[25] *See Griggs v. Duke Power Co.*, 401 U.S. 424, 429-33 (1971).
[26] *Id.* at 432 (explaining that the complainant must show that an employer has a "particular employment practice" that causes a disparate impact).
[27] *Newport News Shipbuilding and Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669, 682 (1983).

Some wellness programs offer voluntary activities and benefits for all employees, such as flex-time for exercise or reduced gym memberships, geared towards encouraging employees to improve and maintain their health. But wellness programs that tie rewards or fees to health benchmarks could be expected to have an adverse impact on women and racial minorities, because women and racial minorities are more likely to experience the most serious health disparities. For example, women are more likely than men to have medical conditions such as obesity[28] and arthritis.[29] Racial minorities are more likely to face heart disease,[30] obesity[31] or diabetes.[32] Over one-third of African-American women over age 45 report fair or poor health, and almost 30 percent have diabetes.[33] African-American women also suffer from the greatest obesity rates.[34] African-Americans have the highest mortality rate of any racial and ethnic group for all cancers combined.[35] They are twice as likely to be diagnosed with diabetes compared to non-Hispanic whites,[36] and also 40 percent more likely to have high blood pressure.[37] Hispanic adults are 1.7 times more likely than non-Hispanic white adults to have been diagnosed with diabetes,[38] and twice as likely to have certain types of cancer compared to non-Hispanic white Americans.[39] Even when income, health insurance and access to care are accounted for, disparities remain.[40] While well-designed, nondiscriminatory wellness programs that seek to combat these conditions and improve employees' health may be a worthy endeavor, wellness programs that merely seek to shift costs depending on health benchmarks may run afoul of the law.

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[28] Cynthia L. Ogden et al., Nat'l Center for Health Statistics, Obesity Among Adults in the United States – No Statistically Significant Change Since 2003-2004 1 (2007), *available at*: http://www.cdc.gov/nchs/data/databriefs/db01.pdf.

[29] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Weekly Report: Prevalence of Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation – United States, 2010-2012 (Nov. 8, 2013), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6244a1.htm.

[30] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Weekly Report: Prevalence of Heart Disease – United States, 2005, Table 1 (Feb. 16, 2007), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5606a2.htm.

[31] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Weekly Report: Differences in Prevalence of Obesity Among Black, White, and Hispanic Adults – United States, 2006-2008 (July 17, 2009), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5827a2.htm.

[32] Ctrs. for Disease Control and Prevention, Age-Adjusted Incidence of Diagnosed Diabetes per 1,000 Population Aged 18-79 Years, by Race/Ethnicity, United States, 1997-2011, http://www.cdc.gov/diabetes/statistics/incidence/fig6.htm (last visited Jan. 28, 2015).

[33] *See* Salganicoff, et al., *supra* note 4.

[34] *Id.*

[35] U.S. Dep't Health & Human Services, Office of Minority Health, Cancer and African Americans, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=16 (last accessed Jan. 28, 2015).

[36] U.S. Dep't Health & Human Services, Office of Minority Health, Diabetes and African Americans, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=18 (last accessed Jan. 28, 2015).

[37] U.S. Dep't Health & Human Services, Office of Minority Health, Heart Disease and African Americans, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19 (last accessed Jan. 28, 2015).

[38] U.S. Dep't Health & Human Services, Office of Minority Health, Diabetes and Hispanic Americans, http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63 (last accessed Jan. 28, 2015).

[39] U.S. Dep't Health & Human Services, Office of Minority Health, Cancer and Hispanic Americans, http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlID=54&ID=3323 (last accessed Jan. 28, 2015).

[40] Ctrs. for Disease Control & Prevention, Health Disparities and Inequalities Report – United States, 2013, Summary, *available at*: http://www.cdc.gov/mmwr/pdf/other/su6203.pdf.

Employers have encountered difficulty in attempting to justify a wellness program that disparately impacts a protected group. If a plaintiff is able to show that the employer's wellness program adversely impacts a protected group, the employer must demonstrate that the policy is "consistent with business necessity."[41] The employer must show that the program is "necessary to the safe and efficient operation of the business"[42] and "of great importance to job performance."[43] Proof of "mere rationality" is not enough.[44] The policy is not a business necessity "if an alternative practice better effectuates its intended purpose or is equally effective but less discriminatory."[45]

Although issues of economy can be considered, courts have concluded that cost savings alone cannot justify a policy or practice that results in a disparate impact.[46] The employer would likely encounter difficulty demonstrating that any cost savings associated with wellness programs are "necessary to the safe and efficient operation of the business,"[47] particularly when there is scant evidence establishing that wellness programs have resulted in measurably improved health outcomes for employees.[48] Although reducing health care costs is arguably a factor a court might consider, the employer would most likely need to show that there was no other solution to lowering costs that did not result in a disparate impact. Linking financial rewards to biometrics or other standards that may not correlate to underlying health and adopting wellness programs that disproportionately harm members of a protected group runs contrary to the spirit and the letter of Title VII.

B. The Americans with Disabilities Act: Wellness programs that disproportionately impose penalties or deny rewards to people with disabilities may violate the Americans with Disabilities Act (ADA).

The ADA prohibits employment discrimination on the basis of disability and limits an employer's ability to make disability-related inquiries and to require medical examinations.[49] Generally, the examination or inquiry must be made on a post-offer basis for employment and either be "job-related and consistent with business necessity," or a voluntary medical examination, as "part of an employee health program available to employees at that work site."[50]

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[41] Civil Rights Act of 1991 § 105(a), 42 U.S.C. § 2000e-2(k)(1)(A)(i).
[42] *Ricci v. DeStefano*, 557 U.S. 557, 623 n. 3 (2009) (citing *Robinson v. Lorillard Corp.*, 444 F.2d 791, 798 (4th Cir. 1971)).
[43] *Williams v. Colorado Springs, Colo., Sch. Dist. No. 11*, 641 F.2d 835, 841 (10th Cir. 1981).
[44] *Jones v. Lee Way Motor Freight, Inc.*, 431 F.2d 245, 249 (10th Cir.), *cert. denied*, 401 U.S. 954 (1970).
[45] *Ricci*, 557 U.S. at 635 (quoting *Robinson*, 444 F.2d at 798, n. 7).
[46] *Robinson*, 444 F.2d 791, 799, n.8; *U.S. v. N. L. Industries, Inc.*, 479 F.2d 354 (8th Cir. 1973); *Johnson v. Pike Corp. of America*, 332 F. Supp. 490 (C.D. Cal. 1971).
[47] *Ricci*, 557 U.S. at 623 n. 3 (2009) (citing *Robinson*, 444 F.2d at 798 (4th Cir. 1971)).
[48] *See supra* note 2.
[49] 42 U.S.C. §§ 12101 *et seq*.
[50] 42 U.S.C. § 12112(d); *see also Watson v. City of Miami Beach*, 177 F.3d 932, 935 (11th Cir. 1999); *Tice v. Centre Area Transp. Authority*, 247 F.3d 506, 514 n. 7 (3rd Cir. 2001).

Wellness plans and health risk assessments may be prohibited under the ADA's "no medical exams or inquiries" provision if they are not voluntary.[51] The level of inducement, or more specifically, the value of the incentive for taking the health risk assessment, may impact whether the medical examination or inquiry is truly voluntary.[52] Financial penalties for failure to meet health criteria also can have a disparate impact on individuals with disabilities. For example, wellness programs run afoul of the ADA if they penalize employees who fail to have normal blood glucose or cholesterol levels, who fall within a certain range of weight or blood pressure, or who cannot participate in a walking or other exercise program due to a disability. In short, a wellness program that requires inappropriate disability-related inquiries, offers reduced benefits, or carries financial penalties for individuals with disabilities can subject an employer to liability under the ADA.

C. The Genetic Information Nondiscrimination Act: Wellness plans that involve genetic information or testing can run afoul of the Genetic Information Nondiscrimination Act (GINA).

GINA restricts an employer's ability to inquire about family health history or other "genetic information" as part of a program of wellness incentives under a group health plan.[53] In connection with any group health plan or health insurer, GINA prohibits the covered entity from increasing premiums or contribution amounts based on genetic information; requesting or requiring an individual or family member to undergo a genetic test; and requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for "underwriting purposes."[54] Employers must ensure that wellness programs and any associated financial incentives or penalties comply with GINA and its implementing regulations.[55] The regulations and the EEOC's June 24, 2011 opinion letter clarify that GINA prohibits employers from offering financial inducements to encourage employees to provide genetic information as part of a wellness program.[56]

D. The Age Discrimination in Employment Act: Wellness programs that disproportionately impose penalties or deny rewards to older workers may violate the Age Discrimination in Employment Act (ADEA).

The ADEA prohibits discrimination against persons over the age of 40.[57] In pertinent part, the ADEA makes it illegal for an employer to "… discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age."[58] The statute specifically prohibits "the reduction of the rate of an employee's benefit

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[51] *See* Equal Employment Opportunity Comm'n, ADA Enforcement Guidance: Preemployment Disability-Related Questions and Medical Examinations, http://www.eeoc.gov/policy/docs/medfin5.pdf.
[52] *Id.*
[53] 42 U.S.C. §§ 2000ff-1 to 2000ff-11.
[54] 42 U.S.C. § 1320d-9.
[55] 29 C.F.R. § 1635.8.
[56] 29 C.F.R. § 1635.8(b)(2)(ii).
[57] 29 U.S.C. §§ 621 *et seq*.
[58] 29 U.S.C. § 623.

accrual, because of age."[59] An increase to a health insurance premium could constitute an adverse action under the ADEA, and an employer cannot discriminate against older workers in the provision of that benefit.

As under Title VII, an ADEA plaintiff may proceed under a theory of disparate treatment or disparate impact.[60] If the plaintiff has evidence that the employer *intended* to discriminate against older workers through a wellness program, the plaintiff may proceed with a claim of disparate *treatment*. An employer may also violate the ADEA by utilizing a facially neutral employment policy or practice that has an adverse *impact* on older workers. When an employee identifies an employment practice that causes a disparate impact,[61] the employer must show that a "reasonable factor other than age" motivated the policy.[62] Under the ADEA's implementing regulations, a "reasonable factor other than age" is a non-age factor that is "objectively reasonable when viewed from the position of a prudent employer mindful of its responsibilities under the ADEA...".[63] Factors a court could consider when determining whether the policy is reasonable include: the extent to which the factor is "related to the employer's business purpose," whether the factor was administered "fairly and accurately" and the employer considered the impact on older workers and the extent of the harm suffered.[64]

A wellness program may violate the ADEA if it has a disparate impact on older employees, who are more likely to suffer from a range of chronic conditions (some, if not all of which also would qualify as disabilities under the Americans with Disabilities Act of 1990[65] and the Rehabilitation Act of 1973,[66] both as amended). Studies have shown that obesity,[67] hypertension,[68] high cholesterol[69] and low bone density, [70] as well as more serious conditions such as diabetes,[71] heart disease[72] and arthritis[73] are strongly correlated with age. Obesity is far more prevalent among the

[59] Age Discrimination in Employment Act, 29 U.S.C.A. § 623(i)(1)(A).
[60] *Smith v. City of Jackson*, 544 U.S. 228, 240 (2005).
[61] *Meacham v. Knolls Atomic Power Lab.*, 554 U.S. 84, 100 (2008).
[62] *Id.* at 93-98; 29 C.F.R. § 1625.7.
[63] 29 C.F.R. § 1625.7(e)(1).
[64] 29 C.F.R. § 1625.7(e)(2).
[65] 42 U.S.C. §§ 12101 *et seq*.
[66] 29 U.S.C. §§ 701 *et seq*.
[67] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Report: Vital Signs: State-Specific Obesity Prevalence Among Adults – United States, 2009 (Aug. 3, 2010), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm59e0803a1.htm.
[68] Ctrs. for Disease Control and Prevention, High Blood Pressure Facts, http://www.cdc.gov/bloodpressure/facts.htm (last visited Jan. 28, 2015).
[69] Ctrs. for Disease Control and Prevention, High Blood Cholesterol: Conditions, http://www.cdc.gov/cholesterol/conditions.htm (last visited Jan. 28, 2015).
[70] U.S. Dep't of Health & Human Services, Office of the Surgeon General, Bone Health and Osteoporosis: A Report of the Surgeon General, Ch. 4, Oct. 14, 2004, *available at* http://www.ncbi.nlm.nih.gov/books/NBK45513/.
[71] U.S. Dep't of Health & Human Services, Office of Women's Health, Diabetes Factsheet, http://womenshealth.gov/publications/our-publications/fact-sheet/diabetes.html.
[72] U.S. Dep't of Health & Human Services, Nat'l Heart, Lung & Blood Inst., Who Is at Risk for Heart Disease?, http://www.nhlbi.nih.gov/health/health-topics/topics/hdw/atrisk.html.
[73] Ctrs. for Disease Control and Prevention, Arthritis: The Nation's Most Common Cause of Disability, http://www.cdc.gov/chronicdisease/resources/publications/aag/arthritis.htm.

elderly than the general population.[74] Almost 75 percent of individuals aged 65 and over have at least one chronic illness,[75] and at least 50 percent have two chronic illnesses.[76] Thus wellness programs that penalize employees for failing to satisfy certain biometric benchmarks might be expected to disproportionately impact older workers.

As detailed below,[77] there is little reliable evidence that punitive wellness programs do more than shift costs to employees. Thus, a court could find that there is insufficient evidence to establish a defense to a disparate impact claim. Indeed, the factors laid out in the EEOC's regulations weigh against these programs.[78] There is little evidence that a wellness program is "related to the employer's business purpose."[79] Punitive wellness programs that penalize older workers whether directly, or indirectly through unattainable employee incentives, should not be deemed to be administered "fairly and accurately."[80] Under the last factor – harm to the employee – it is clear that if a wellness program imposes a financial penalty, this can significantly reduce an employee's earnings.[81] As such, the ADEA protects against wellness programs that disproportionately penalize older workers.

The ADEA prohibits employers that offer health care benefits to their employees from discriminating against older workers by refusing to cover them or by reducing their benefits because of their age. However, an employer may be permitted under the ADEA to reduce benefits of older workers as long as the same amount of money is *spent* on older workers as is spent on younger workers.[82] Yet there are several ways that a wellness program might not be sheltered by this defense provided by the ADEA. First, the exception is only available to employers when "justified by significant cost consideration."[83] Second, in the context of a contributory health plan, wherein the employer and employee both contribute to the cost of the premium, the employer may increase the employee's premium contribution as the employee ages, but the *proportion* that the employee pays cannot be higher than the proportion paid by younger employees.[84] Thus, an employer would run afoul of the ADEA if the proportion of older workers' contributions increases as a result of financial penalties or increased premiums associated with wellness programs.

[74] Ctrs. for Disease Control and Prevention, Older Persons' Health, http://www.cdc.gov/nchs/fastats/older-american-health.htm (last visited Jan. 28, 2015).
[75] E. Calkins, et al. New Ways to Care for Older People: Building Systems Based on Evidence (1999).
[76] L.P. Fried LP & J.M. Guralnik, *Disability in older adults: evidence regarding significance, etiology, and risk*, J. 45 Am. Geriatric Soc. 92-100 (1997).
[77] *See supra* note 2.
[78] 29 C.F.R. §1625.7(e)(2).
[79] §1625.7(e)(2)(i).
[80] §1625.7(e)(2)(ii).
[81] §1625.7(e)(2)(v).
[82] 29 U.S.C. § 623(f)(2)(b).
[83] 29 C.F.R. § 1625.10(a)(1).
[84] *Id.*

E. Equal Pay Act: Wellness plans that impose financial penalties can run afoul of the Equal Pay Act, which requires that women and men are compensated equally for equal work.[85]

The Department of Labor's regulations implementing the Equal Pay Act make clear that equal wages include fringe benefits.[86] The EEOC also has recognized that the Equal Pay Act requires equal compensation for not only salaries and bonuses, but also employment benefits.[87] Indeed, courts have awarded lost benefits in Equal Pay Act cases.[88] Thus, an employer wellness program could run afoul of the Equal Pay Act if it penalizes employees by granting different benefit levels to women and men with the same or similar work duties.

F. The Health Insurance Portability and Accountability Act (HIPAA): Wellness plans that discriminate in health coverage based on health factors can run afoul of the Health Insurance Portability and Accountability Act. [89]

HIPAA prohibits discrimination in participation, eligibility, premiums and contributions for health coverage[90] based on factors like health status, medical condition, medical history and genetic information.[91] The Departments of Treasury, Labor, and Health and Human Services are expected to issue a final regulation implementing HIPAA's nondiscrimination provisions in the near future. The proposed rule sets certain parameters for employer wellness programs. For example, wellness programs must be made available to all similarly-situated employees. The proposed rule states that wellness programs must be reasonably designed to promote health or prevent disease. The proposed rule also states that wellness programs must provide a reasonable alternative to a health-based standard for individuals for whom it is unreasonably difficult of medically inadvisable to meet the initial standard.

III. The EEOC's Important Role in Evaluating Wellness Programs' Punishments and Rewards

The EEOC has a responsibility to investigate and, where appropriate, develop systemic and impact litigation to protect the most vulnerable workers, including low-wage workers who would be impacted by wellness program cost-shifting measures that penalize protected groups. Investigators and litigators should be trained to identify red-flags. In addition to identifying programs that unlawfully raise insurance premiums for vulnerable employees, investigators must also pay particular attention to programs that purportedly offer "rewards" to participating employees but result in fewer employees participating in the employer-provided health insurance. Employees who receive "rewards" are better able to utilize the employer's health

[85] 29 U.S.C. § 206(D)(1).
[86] 29 C.F.R. § 1620.10.
[87] Equal Employment Opportunity Comm'n, Equal Pay/Compensation Discrimination, http://www.eeoc.gov/laws/types/equalcompensation.cfm (last visited Jan. 28, 2015).
[88] *See, e.g., Meadows v. Ford Motor Co.*, 510 F.2d 939 (6th Cir.1975), *cert. denied*, 425 U.S. 998 (1976); *Grove v. Frostburg Nat. Bank*, 549 F. Supp. 922, 946 (D. Md. 1982).
[89] 26 U.S.C. § 9802; 29 U.S.C. § 1182; 42 U.S.C. § 300gg-1.
[90] 26 C.F.R. § 54.9802–1(g); 29 CFR 2590.702(g); 45 C.F.R. § 146.121(g).
[91] United States Dep't of Labor, Frequently Asked Questions: The HIPAA Nondiscrimination Requirements, http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html (last accessed Jan. 28, 2015).

benefits, while those who do not participate in wellness programs and do not receive these "rewards" may no longer be able to afford health insurance.

The EEOC's efforts are particularly important in light of the fact that there is little data supporting employer wellness programs that try to change employee behavior by raising insurance premiums or tying rewards to health outcomes. There is scant – if any – empirical evidence that monetary rewards can result in sustained weight loss.[92] Crucially, there is no independently evaluated research demonstrating that linking the cost of employer-sponsored insurance to certain biometrics has an impact on health outcomes.[93]
For example, biometric markers are overwhelmingly common in wellness programs generally. According to a recent survey, 90 percent of companies that have outcomes-based wellness programs use a weight-related standard and 75 percent use blood pressure, cholesterol and tobacco use.[94] However, requiring all employees to meet biometric markers such as BMI, blood pressure and cholesterol is not reasonably related to improving employees' health, particularly when the same standards are applied indiscriminately to all employees. These biometrics are influenced by a range of genetic and environmental determinants that do not affect all employees equally and are largely out of an individual's control.[95] BMI, in particular, is not an accurate assessment of health, as it is designed as a measure of public health risk, not as a marker for individual goals.[96] Penalizing all individuals with a BMI or body weight over a certain number ignores the science that shows that many individuals who are not overweight nevertheless have a high BMI, and, conversely, that many overweight people are in good health and whose blood pressure and cholesterol are in the healthy range.[97]

In addition, whether because of genetic or environmental factors, some chronic conditions do not significantly improve over time. For example, there is extensive scientific evidence indicating that employers cannot expect their employees to lose large amounts of weight and maintain significant weight loss over time, even with intensive treatment options.[98] There is also strong scientific research showing that individuals can improve their health by taking small steps

[92] V. Paul-Ebhohimhen & A. Avenell, *Systematic review of the use of financial incentives in treatments for obesity and overweight*, 9 Obesity Reviews 355-67 (Oct. 23, 2007).
[93] Kevin G. Volpp, David A. Asch, Robert Galvin & George Loewenstein, *Redesigning Employee Health Incentives – Lessons from Behavioral Economics*, 365 N. Engl. J. Med. 388-390 (Aug. 4, 2011).
[94] Health Enhancement Research Org., et. al, Fact Sheet: Statistics About Workplace Wellness (July 2012), http://hero-health.org/wp-content/uploads/2014/03/FactSheet_wellness-stats_FINAL_071512.pdf.
[95] L. Perusse & C. Bouchard, *Gene-diet interactions in obesity*. Am. J. Clinical Nutrition; vol. 72 (5 Suppl.), pp. 1285S-1290S (2000).
[96] Jon R. Gabel et al., *Obesity and the Workplace: Current Programs and Attitudes Among Employers and Employees*, 28 Health Affairs 46-56 (2009).
[97] Antony D. Karelis, et al. *Metabolic and body composition factors in subgroups of obesity: What do we know*? J. 89 Clinical Endocrinology & Metabolism 2569-2575 (June 2004); Neil Ruderman, et. al, *The metabolically obese, normal weight individual revisited*, 47 Diabetes 699-713 (1998); Adam Gilden Tsai & Thomas A. Wadden, *Systematic review: An evaluation of major commercial weight loss programs in the United States*, 142 Annals of Internal Medicine 56-66 (Jan. 4, 2005).
[98] M.J. Franz, et al., *Weight-loss outcomes: A systematic review and meta-analysis of weight-loss clinical trials with a minimum 1-year follow-up*. 107 J. Am. Dietetic Ass'n 1755-67 (2007); L.P. Svetkey, et al., *Comparison of strategies for sustaining weight loss*, 299 JAMA 1139-1148 (March 12, 2008).

towards weight loss.[99] Yet an employee who took such a step – for instance, lowering her BMI from 35 to 32, where the employer's benchmark is set at 30 – would not escape a penalty under a punitive wellness program when there is one BMI benchmark required for all employees.

Some punitive wellness programs charge employees higher health insurance premiums simply for failing to reach certain benchmarks. Safeway's "Healthy Measures" program, for example, tests participating employees' tobacco use, weight, blood pressure and cholesterol levels.[100] Employees who fail these tests pay $780 more for annual individual coverage and $1,560 more for annual family coverage than employees who pass the tests.[101]

Many punitive wellness programs penalize employees whether or not they choose to participate in the programs. Scotts Miracle-Gro has implemented a program that imposes penalties for failure to participate in some aspects of the program.[102] Scotts' wellness program offers a health-risk appraisal called "Health Quotient."[103] Employees who choose not to participate pay a $40 per month insurance premium surcharge.[104] If an employee takes the appraisal and is in the mid- to high-tier range of risk levels, she can opt to consult a health coach and take steps to lower risks.[105] However, if the employee does not take further action, she will pay a $67 insurance premium surcharge – or penalty – per month.[106] Scotts' policy is a double-edged sword – if employees choose not to be evaluated, they incur a penalty, but agreeing to undergo the evaluation can come with even greater costs.

Several states penalize employees if their BMI – one of the most popular biometrics used by employers to measure health[107] and obesity[108] – exceeds a certain threshold. The state of Alabama has imposed financial penalties on its employees who have a BMI over 30,[109] and the state of North Carolina has denied its employees access to better health insurance options if an individual's BMI is above a certain measure.[110]

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[99] Rena R. Wing & Suzanne Phelan, *Long-term weight loss maintenance*, 82 Am. J. Clinical Nutrition 222S-5S (2005); Thomas A. Wadden, et al., *Efficacy of lifestyle modification for long-term weight control*. 12 Obesity Research 151S-162S.11 (December 2004).

[100] Steven A. Burd, *How Safeway Is Cutting Health-Care Costs*, Wall St. J., June 12, 2009, http://wsj.com/article/SB124476804026308603.html.

[101] *Id.*

[102] Larry Hand, *Employer health incentives: Employee wellness programs prod workers to adopt healthy lifestyles*, Harvard Sch. Pub. Health Mag., (Winter 2009), *available at* http://www.hsph.harvard.edu/news/magazine/winter09healthincentives.

[103] *Id.*

[104] *Id.*

[105] *Id.*

[106] *Id.*

[107] Mike Stobbe, *Dieting for dollars? More U.S. employees trying it*, Fort Worth Star Telegram, June 2, 2010, http://www.star-telegram.com/living/family/moms/article3825613.htmlAs many as one-third of employers plan to implement financial incentive programs to encourage employees to reduce their BMI or other biometric markers of health. *Id.*

[108] Obesity Action Coalition, Measuring Weight and Obesity, http://www.obesityaction.org/understanding-obesity/measuring-weight (last visited Jan. 28, 2015).

[109] Shari Roan, *Alabama to place 'fat tax' on obese state employees*, L.A. Times Blog, Aug. 25, 2008, http://latimesblogs.latimes.com/booster_shots/2008/08/alabama-places.html.

[110] 2009 N.C. Sess. Laws 16, *available at*

Notwithstanding the lack of evidence to demonstrate their efficacy, many employers have already implemented, or plan to implement, wellness programs that penalize employees who do not meet health criteria set by the employer, and that is cause for concern to those with an eye on nondiscrimination protections and makes even more important the EEOC's role in ensuring nondiscrimination.

Employers are increasingly relying on punitive wellness programs to control the cost of health benefits.[111] A 2010 survey by Hewitt of nearly 600 large U.S. employers (representing more than 10 million employees) found that nearly one-half (47 percent) already used or planned to use financial penalties over the next three to five years for employees. Of those companies using or planning to use penalties, the majority (81 percent) say they would do so through higher benefit premiums. Increasing deductibles and out-of-pocket expenses were also cited as possible penalties.[112] Interest in punitive wellness programs is on the rise. In Hewitt's most recent survey, published in March 2013, 58 percent of employers surveyed planned to impose consequences on participants who do not take appropriate actions for improving their health.[113]

Because women, racial minorities and older workers tend to be less likely to meet rigid health benchmarks, they are more likely to have to pay increased costs when financial penalties or rewards are associated with those benchmarks. As such, punitive wellness programs can run afoul of equal employment opportunity laws and the EEOC's role in identifying these programs is critical.

IV. Conclusion

When punitive wellness programs impose costs or withhold rewards from protected groups they violate well-established nondiscrimination laws. We urge this committee to support the EEOC's enforcement efforts to enforce nondiscrimination protections to ensure that employer wellness programs do not operate as a subterfuge for unlawful discrimination. Proper investigation and oversight by the EEOC is critical to ensuring that employer wellness programs help employees achieve meaningful improvements in health outcomes without running afoul of equal employment opportunity laws. Women, racial minorities and older workers are more likely to experience significant health disparities and are particularly vulnerable to chronic illnesses and therefore most likely to be impacted by wellness programs that discriminate. Employers should not use punitive wellness programs to shift costs disproportionately to these groups, particularly in light of the lack of evidence that punitive wellness programs actually improve employee wellness or decrease overall health care costs. Without congressional support, the EEOC's ability

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http://www.ncga.state.nc.us/Sessions/2009/Bills/Senate/PDF/S287v8.pdf.

[111] *See* Michelle M. Mello, et al., *Wellness Programs and Lifestyle Discrimination – The Legal Limits*, 359 N. Engl. J. Med. 192-199 (2008).

[112] Bloomberg.com, *Hewitt Survey Shows Growing Interest Among U.S. Employers to Penalize Workers for Unhealthy Behaviors* (March 17, 2010), http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aqKgAGxn8bBA.

[113] Aon Hewitt Survey Highlights Important Role of Incentives in U.S. Employers' Efforts to Improve Workforce Health and Performance, (2013), http://aon.mediaroom.com/2013-03-25-Aon-Hewitt-Survey-Highlights-Important-Role-of-Incentives-in-U-S-Employers-Efforts-to-Improve-Workforce-Health-and-Performance.

to promote equal opportunity and enforce civil rights laws for U.S. workers will be compromised.

Thank you for the opportunity to share our comments. We look forward to continuing to work with Congress and the Administration to ensure nondiscrimination in employer wellness programs.