Wellness Programs, the ADA, and GINA: Framing the Conflict

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PRACTITIONERS’ NOTES

WELLNESS PROGRAMS, THE ADA, AND GINA: FRAMING THE CONFLICT

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I. INTRODUCTION

The Patient Protection and Affordable Care Act ("ACA") is a vast law that encompasses a number of policy goals and initiatives. Perhaps the most important goal, however, is a reduction in the overall cost of healthcare—also known as “bending the cost curve.”

The expansion of incentives that companies can offer as part of employee wellness programs—initiatives that encourage healthy behaviors, monitor health and, sometimes, provide rewards for the achievement of certain health outcomes—is one of the many cost

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* E. Pierce Blue currently serves as a Special Assistant and Attorney Advisor to Commissioner Chai R. Feldblum of the U.S. Equal Employment Opportunity Commission. The views expressed in this article do not represent the views of Commissioner Feldblum or the Commission. As of the writing of this article, the Commission has held a hearing on wellness programs and the ADA and GINA but has not issued a policy pronouncement on the application the ADA and GINA to wellness programs. The author understands that persons might be tempted to scrutinize this article for hints about what the Commission may do in this area. However, the author stresses that this piece contains no such hints.


2. See e.g., THOMAS DASCHLE & DAVID NATHER, GETTING IT DONE: HOW OBAMA AND CONGRESS FINALLY BROKE THE STALEMATE TO MAKE WAY FOR HEALTH CARE REFORM 157 (2010) (“If Congress didn’t find a way to keep healthcare costs from rising out of control, the public would never consider health care reform to be a success.”); EXEC. OFFICE OF THE PRESIDENT, TRENDS IN HEALTH CARE COST GROWTH AND THE ROLE OF THE AFFORDABLE CARE ACT 1 (Nov. 2013) (“The Affordable Care Act (ACA) was passed against a backdrop of decades of rapid growth in health care spending in the United States . . . A key goal of the ACA was to begin wringing these inefficiencies out of the health care system, simultaneously reducing the growth of health care spending – and its burden on families, employers, and state and federal budgets – while increasing the quality of the care delivered.”), available at http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf.
containment measures included in the law. Though comprehensive data on the impact of the programs is limited, companies and benefit experts believe they have great potential. The CEO of Safeway even claimed that widespread adoption could reduce the nation’s overall health costs by forty percent.

But there is a problem with the statutory scheme that Congress put in place to regulate these programs. As commentators and the Department of Labor itself noted when it first issued rules on the use of incentives in wellness programs in 2006, a number of laws, including the Americans with Disabilities Act (“ADA”) and the Genetic Information Nondiscrimination Act (“GINA”), could pose problems for companies seeking to implement incentive programs. And though it was expected that Congress would remedy that problem in the ACA, the law is silent on how the two laws should interact.

4. See generally Employer Health Benefits 2010 Annual Survey, HENRY J. KAISER FAM. FOUND. & HEALTH RES. & EDUC. TR., at 2, 200 (forty-four percent of total respondents stated that their wellness programs reduced health costs); Leonard L. Berry et al., What’s the Hard Return on Employee Wellness Programs? HARV. BUS. REV., Dec. 2010, at 105, 106 (citing positive outcomes reported by private-sector employers who use wellness programs on health care savings, absenteeism, and employee satisfaction).
6. See § 300gg-4(j) (Westlaw).
8. The preamble to the 2006 HIPAA regulations included the following paragraph:

Many other laws may regulate plans and issuers in their provision of benefits to participants and beneficiaries. These laws include the ADA, Title VII, the Family and Medical Leave Act, ERISA’s fiduciary provisions, and State law. The Departments have not attempted to summarize the requirements of those laws in the HIPAA nondiscrimination rules. Instead, these rules clarify the application of the HIPAA nondiscrimination rules to group health plans, which may permit certain practices that other laws prohibit. Nonetheless, to avoid misleading plans and issuers as to the permissibility of any plan provision under other laws, the Departments included, in both paragraph (h) and paragraph (b) of the regulations, references to the potential applicability of other laws. Employers, plans, issuers, and other service providers should consider the applicability of these laws to their coverage and contact legal counsel or other government agencies such as the EEOC and State insurance departments if they have questions under those laws.

71 Fed. Reg. 75014, 75015 (Dec. 13, 2006); see also infra Part II.b.
9. The ACA amendments state that wellness programs will not “violate this section” if they comply with the standards set forth in the amendment, leaving open the possibility that plans which comply with that section might still violate other laws. Further, anecdotal evidence suggests that Congress considered and rejected the following language which would have explicitly exempted wellness plans from the ADA, GINA, and other statutes:
Perhaps part of the reason why Congress failed to clarify the intersection of the ADA, GINA and ACA on this issue is that the problem has not been clearly defined. One frequently hears that uncertainty exists but it is rare to see a full explanation of the nature of the problem.

This is, of course, a very important question. The nature of a problem tells one quite a bit about how solutions need to be framed. The goal of this article is to set forth the ways in which one could define this tension by working through the relevant statues, regulations, legislative histories, and case law. It does not put forward a firm conclusion on which frame is best or most appropriate. The law is simply too much in flux for that to be worthwhile. Rather, the hope is that defining the various frames will provide a valuable service to the policy debate around this issue.

II. What Are Wellness Plans?

The term wellness program encompasses a wide array of employer and insurer initiatives aimed at improving the health of employees and policy users.10 The plans range from the mundane—offering discounted gym memberships or sponsoring daily walks11—to the complex—providing premium reductions for weight loss or the achievement of other health goals.12

The use of wellness plans is growing rapidly in the United States.13 According to the Bureau of Labor Statistics ("BLS") National
Compensation Survey, approximately fifty-four percent of full-time employees in the public and private sectors had access to a wellness program in 1998-1999. By 2008, the BLS reported that the number had increased to eighty-two percent. And, in 2013, a survey by the Kaiser Family Foundation found that ninety-nine percent of large firms and seventy-six percent of small firms offered some kind of wellness benefit.

There is no study or report that defines what the “average” wellness plan looks like. However, the use of comprehensive surveys of employee health called Health Risk Assessments (“HRAs”) appears to be a common feature in many. The contents of the HRAs vary but they tend to include questions covering the employee’s medical status—such as presence or absence of heart disease, smoking history, etc.—and current biometric readings—such as blood pressure, cholesterol, body mass index, etc. Information gathered from the HRA is then used by plan administrators to alert participants to health risks and guide users to specific wellness programs (which may or may not have incentives attached).

In order to incentivize the completion of the HRAs and participation in wellness programs, employers will often offer a penalty or reward. The size of these rewards/penalties varies widely. The Kaiser Family Foundation Survey found that fifty-five percent of large firms that used HRAs offered some financial incentive. Examples of financial incentives used by employers completing the survey ranged from smaller premium/deductibles for participants to gift cards or merchandise.

There have also been a handful of anecdotal reports about specific incentive programs used by large corporations. In March of 2013, for instance, it was reported that CVS planned to impose a fifty dollar per month penalty on all employees who failed to participate in its wellness program.

14. See id.
15. See id.
17. A Kaiser Family Foundation Survey found that twenty-three percent of small firms with wellness plans utilized an HRA and fifty-five percent of large firms with wellness plans used an HRA. See id. at 203.
18. See id. at 203-04.
19. See id. at 203.
20. See id.
21. See id. at 209.
22. See id. at 210.
23. See id. at 202.
plan—a plan that required the completion of an HRA. And, in 2009, during the debate over the ACA, the CEO of Safeway, Inc. wrote a widely disseminated op-ed detailing the company’s program which offered a sixty-five dollar per month reward to individuals who met four health benchmarks—tobacco use, healthy weight, acceptable cholesterol, and acceptable blood pressure.

III. THE LEGAL CONTEXT

There are four laws involved in this legal puzzle. The ACA,\textsuperscript{26} the Health Insurance Portability and Accountability Act (“HIPAA”),\textsuperscript{27} the ADA,\textsuperscript{28} and the Genetic Information Nondiscrimination Act (“GINA”).\textsuperscript{29} For our purposes, these laws can be grouped into two categories. The first—ACA and HIPAA—dictate the scope of incentives that group health plans and group health insurance issuers can offer while still complying with HIPAA’s requirement that plans and issuers not discriminate on the basis of health factors.\textsuperscript{30} The second—ADA and GINA—govern when and how employers can seek medical information from their employees.\textsuperscript{31} The following sections detail how the laws in each of these categories, and the regulations and guidance that accompany them, if applicable, impact wellness programs. The section concludes with a discussion on the applicability of the ADA’s health care safe harbor to wellness programs.

A. HIPAA and the ACA

HIPAA and the ACA impact wellness programs through the


\textsuperscript{25}See Burd, supra note 5.


\textsuperscript{29}29 C.F.R. § 1635 (2013).


nondiscrimination provision of the law. Specifically, HIPAA prohibits group health plans and group health insurance issuers from discriminating on the basis of health factors such as disability, health status, genetic information, medical history and claim experience in enrollment eligibility, and premium contributions. Essentially, a covered entity cannot require person A to pay a higher premium than similarly situated person B simply because person A has a disability or medical condition.

However, the law also states that the nondiscrimination provisions are not to be read to “prevent a group health plan 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.”

The Department of Labor, which enforces the nondiscrimination provisions of HIPAA, has read this exception to permit the operation of programs that shift benefits, premiums, or contributions based on participation in a wellness program as long as they meet certain standards. Those standards vary based on whether a reward is or is not dependent on the achievement of a health outcome.

Programs that offer a reward simply for participation in a program are called “participatory wellness programs.” These types of plans are acceptable as long as they are made available to all similarly situated individuals. For instance, a plan that gives gift certificates to employees who participate in a diagnostic testing program but does not condition any further rewards or incentives on the results of the test qualifies as a participatory program. Assuming the testing is open to all similarly situated employees, it is acceptable under HIPAA.

Programs that condition a reward on the achievement of “a standard

33. See § 9802(a)-(b); see also Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33158. The factors listed in the statute include: (A) health status; (B) medical condition (including both physical and mental illnesses); (C) claims experience; (D) receipt of health care; (E) medical history; (F) genetic information; (G) evidence of insurability (including conditions arising out of acts of domestic violence); and (H) disability. Id. at § 9802(a)(1).
34. Id. at § 9802 (b)(2)(B).
36. See id.
37. See id. at 33160.
38. See id. at 33161.
39. See id.
[that is] related to a health factor” are labeled “health contingent wellness programs.”\(^{40}\) In order to satisfy HIPAA’s nondiscrimination requirements, the plans must meet five factors. The plan must give “individuals eligible for the program . . . the opportunity to qualify for the reward at least once per year.”\(^{41}\) The size of the reward offered must not “exceed the applicable percentage . . . of the total cost of employee-only coverage under the plan . . .”\(^{42}\) The reward must be available to all similarly situated individuals.\(^{43}\) The program must be “reasonably designed to promote health or prevent disease.”\(^{44}\) And plan materials must inform participants that alternate means of achieving the reward are available.\(^{45}\)

The ACA directly impacted one of these factors—the cap on the overall size of the award that plans were permitted to offer.\(^{46}\) Prior to the ACA, the Department of Labor regulations defined the applicable percentage as a maximum of twenty percent of the total cost of coverage under the plan.\(^{47}\) The ACA codified the cap at thirty percent and gave the Secretaries of Health and Human Services, Labor, and Treasury the discretion to increase it to fifty percent of the total cost of coverage if they felt an increase was appropriate.\(^{48}\) In final regulations issued in June of 2013, the Secretaries opted to use this authority and increased the maximum reward to fifty percent for smoking cessation programs and thirty percent for all other wellness programs.\(^{49}\)

The rest of the factors remain essentially unchanged. Acceptable

\(^{40}\) Id.

\(^{41}\) Id. at 33162.

\(^{42}\) Id.

\(^{43}\) See id. at 33163.

\(^{44}\) Id. at 33162.

\(^{45}\) See id. at 33163.

\(^{46}\) The ACA essentially codified the approach taken by the Department of Labor in its HIPAA regulations. It amended the Public Health Services Act (42 U.S.C. §201 et seq.) provisions on nondiscrimination at 42 U.S.C. §300gg-4 by adding paragraph (j). The language in this new paragraph affirms the Department of Labor’s division of wellness plans into “participatory” and “health contingent programs” and largely reiterates the reasonable design, universal applicability and reasonable alternative, frequency of opportunity, and notice requirements set forth by the Department of Labor. That said, there are some ways in which the ACA approach deviates from what the Department of Labor had done previously. For purposes of this article though, those deviations are not significant. See 42 U.S.C.A. § 300gg-4(j) (West, Westlaw through P.L. 113-74 (excluding P.L. 113-66 & 113-73)).


\(^{49}\) See Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33159.
wellness plans must be open to all similarly situated individuals—meaning that if it is either "unreasonably difficult" or "medically inadvisable" for a person to meet a standard, the plan must either waive the standard or work with the person to craft a reasonable alternative standard. The plans must also be based on some objective information showing that they have "a reasonable chance of improving the health of, or preventing disease in, participating individuals"—i.e. the programs cannot act as a "subterfuge for discrimination" on the basis of a health factor. And plans must give adequate notice to participants that alternatives are available.

B. ADA and GINA

The ADA and GINA impact wellness programs in two ways. First, both the ADA and GINA prohibit employers from subjecting employees to medical exams and inquiries related to disability or medical history, subject to certain exemptions. Second, the ADA requires that employers not discriminate against persons with disabilities on the basis of disability in regard to compensation and other terms and conditions of employment. This prohibition includes not making reasonable accommodation to the known physical or mental limitations of an employee.

1. Medical Exams and Inquiries.

The ADA states that:

A covered entity shall not require a medical examination and shall not make medical inquiries of an employee as to whether such employee is an individual with a disability or as to the

50. See 42 U.S.C.A. §§ 300gg-4(j)(3)(D)(i)(I)-(II). For example, say a plan offers rewards to participants who have a cholesterol count below 200. If it is medically impossible for a participant to achieve that goal due to a medical condition, the plan must make an alternative goal, such as a diet or exercise program available upon request, or the plan must develop a goal that is medically feasible for the participant. See generally Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. at 33159.


55. Id. § 12112(b)(5)(A).
nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity. 56

The EEOC defines the term “disability-related inquiry” broadly to include any “question (or series of questions) that is likely to elicit information about a disability.” 57 And the U.S. Equal Employment Opportunity Commission (“EEOC”) reads “job-related and consistent with business necessity” as requiring that an employer have “a reasonable belief based on objective evidence, that: (1) an employee’s ability to perform essential job functions [is or] will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition.” 58

Further, according to EEOC guidance 59 and the majority of circuit courts that have considered the question, 60 this provision is not limited to employees with disabilities. Rather, the language is read as applying to all employees. 61

GINA states that it is “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...” 62 The statute defines the term “genetic information” broadly to include an individual’s genetic tests, the genetic tests of family members, and the manifestation of a disease or disorder in the family members of an individual. 63

Together these two statutes create a general rule that covered entities cannot seek medical information from their employees unless it meets one of the limited exceptions provided. 64

56. Id. at § 12112(d)(4)(A).
58. Id.
59. See id.
60. See Fredenburg v. Contra Costa Cnty. Dept't of Health Services, 172 F.3d 1176, 1182 (9th Cir. 1999) (holding that a person without a disability can bring a claim under 102(d)(4) of the ADA); Griffin v. Steeltek, Inc., 160 F.3d 591, 595 (10th Cir. 1998), cert. denied, 119 S. Ct. 1455 (1999); Roe v. Cheyenne Mountain Resort, 124 F.3d 1221, 1229 (10th Cir. 1997). But see Krocka v. Bransfield, 969 F. Supp. 1073, 1094 (N.D. Ill.) (holding that a plaintiff must be a person with a disability in order to bring a cause of action under 102(d)(4)).
61. See Enforcement Guidance, supra note 57; Fredenburg, 172 F.3d at 1182; Griffin, 160 F.3d at 595; Roe, 124 F.3d at 1229; but see Krocka, 969 F. Supp. at 1094.
64. See supra notes 56, 62 and accompanying text. The ADA has a different set of rules for
The ADA contains three exceptions. First, it permits examinations and inquiries that are “job-related and consistent with business necessity.” 65 Second, it permits inquiries “into the ability of an employee to perform job-related functions.” 66 Third, and most important for our purposes, the ADA permits covered entities to “conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site.” 67

GINA provides one exception. Covered entities can collect genetic information where: (1) “health or genetic services are offered by the employer, including services offered as part of a wellness program;” (2) “the employee provides prior, knowing, voluntary, and written authorization;” (3) “only the employee . . . and the licensed health care professional or board certified genetic counselor involved in providing such services receive individually identifiable information concerning the results of such services;” and (4) “individual identifiable genetic information provided . . . is only available for purposes of such services and shall not be disclosed to the employer except in aggregate terms that do not disclose the identity of specific employees.” 68

So both statutes permit the collection of medical information for “employee health programs” and services offered “as part of a wellness program” as long as certain conditions are met. For the ADA, the primary condition is that the information is provided voluntarily. 69 Under GINA, a person must supply the information voluntarily, with written consent and the employer must make certain that only the person providing the information and the medical professional operating the program have access to individually identifiable information. 70

EEOC guidance currently defines a voluntary submission of information similarly for both statutes. EEOC’s enforcement guidance on medical exams and inquiries under the ADA states that a wellness plan is voluntary “as long as the employer neither requires participation nor penalizes employees who do not participate.” 71 Similarly, the regulations implementing GINA say that an employer may offer applicants and persons who receive provisional job offers. These are outside of the scope of this article so they are not considered. See 42 U.S.C. §§ 12112(d)(2)-(3) (2006).

66. Id. at § 12112(d)(4)(B).
67. Id.
69. See § 12112(d)(4)(B).
70. § 2000ff-1(b)(2).
financial inducements for the completion of HRAs under GINA provided that "the covered entity makes clear . . . that the inducement will be made available whether or not the participant answers questions regarding genetic information"—essentially a statement that a covered entity cannot require an employee to provide genetic information or penalize them for refusing to provide that information.

2. Reasonable Accommodation

The ADA requires that covered entities provide persons with disabilities equal access to benefits and other terms and conditions of employment. This obligation includes providing reasonable accommodation to ensure equal access to benefits unless such accommodation would impose an undue hardship on the finances or operation of the covered entity.

Wellness programs are a part of the benefits and other terms, conditions, and privileges of employment offered by a covered entity. As such, covered entities are under an obligation to provide reasonable accommodation to qualified individuals with disabilities who require such accommodations to enjoy equal access to these programs.

The impact of this requirement on wellness programs is plain. If, due to a disability, a qualified individual with a disability is unable to participate in a wellness program—say because this person’s impairment prevents them from engaging in the activity required (e.g. walking) or because the impairment makes it impossible for the person to achieve a wellness program goal (e.g. cholesterol level below 200)—the covered entity must consider accommodations that would enable the individual to participate. In the walking example, for instance, the covered entity would need to consider an alternate activity that would enable the person to participate—potentially a shorter program if walking is difficult due to disability or some equivalent activity if the person is unable to walk due to a disability. In the cholesterol example, the entity would need to develop an alternate standard that the person is able to meet.

This requirement, of course, is remarkably similar to the "reasonable alternative" standard put forward in the ACA and HIPPA regulations. It is not entirely clear how much overlap there is between the two concepts, however, since "reasonable alternative" is a relatively

74. 29 C.F.R. 1630.9(a) (2013).
75. See id.
new standard and there have been few, if any, ADA accommodation claims related to wellness programs.

C. Seff and the ADA Insurance Safe Harbor

The final wrinkle to consider is the insurance safe harbor language in the ADA and its applicability to wellness programs. Title IV of the ADA contains the following language:

[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.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter. 76

The language was designed to protect the basic business operations of insurance companies—namely, underwriting and classifying risks. 77 Or, as the House Committee on Education and Labor Report put it: “[t]he Committee does not intend that any provisions of this legislation should affect the way the insurance industry does business in accordance

77. See id.
Wellness programs are not traditionally associated with basic risk underwriting. The underwriting process is what determines the premiums that an insurance company will charge a company or individual seeking coverage. It is driven primarily by data and actuarial models. Wellness programs typically enter the process after the premiums are set. They are either offered by the insurance company or a third-party provider and serve as a kind of "bonus option" that can help a company reduce its overall medical costs. The programs are essentially one step removed from basic underwriting.

That said, the association is close enough that some companies have sought to use the safe-harbor as a defense to claims that a wellness program violates the ADA. Seff v. Broward County is the only case to date where this claim has been tested.

In Seff, an employee filed an ADA claim against Broward County, Florida, alleging that its wellness policy, which penalized employees twenty dollars per pay period if they refused to complete an HRA and submit to biometric testing, constituted an unlawful medical inquiry under the ADA. Broward responded by stating that its wellness program was protected by the ADA insurance safe harbor and was not subject to challenge.

The district court agreed with Broward's position and found that its wellness program was a term of a bona fide benefit plan "designed to develop and administer present and future benefit plan using accepted principles of risk assessment." In ruling that the program was covered by the safe harbor, the district court relied heavily on two district court

79. See generally infra note 82 and accompanying text.
83. See e.g. Seff v. Broward Cnty., 691 F.3d 1221, 1222 (11th Cit. 2012).
84. Id.
85. Id. at 1222.
86. Id.
cases interpreting the safe harbor - *Barnes v. Benham*\(^{88}\) and *Zamora-Quezada v. HealthTexas Medical Group*.\(^{89}\)

*Barnes* involved an employee who was terminated after he refused to complete a health questionnaire attached to an application for health insurance benefits and refused to sign a waiver stating that he was offered the opportunity to apply for health benefits.\(^{90}\) The employee claimed that the questionnaire constituted an unlawful medical inquiry.\(^{91}\) The court ruled that the questionnaire fell within the ADA insurance safe harbor as the inquiries were posed “solely for the purpose of underwriting, classifying, and administering risk.”\(^{92}\)

*Zamora-Quezada* touched on the meaning of the term “underwriting.”\(^{93}\) The court, citing the EEOC’s interim guidance on health insurance and the ADA, defined underwriting as “the application of the various risk or risk classes to a particular individual or group for the purposes of determining whether to provide coverage” and risk classification as “the identification of risk factors and the groupings of those factors which pose similar risks.”\(^{94}\)

Seff viewed these cases as supporting a reading of “underwriting and classifying risks” that went beyond the usual process of setting premiums based on actuarial data.\(^{95}\) The district court stated that “[t]hough [the County] is not underwriting or classifying risks on an individual basis, [the County] is underwriting and classifying risks on a macroscopic level so it may form economically sound benefit plans for the future.”\(^{96}\)

The plaintiff appealed this decision to the 11th Circuit. The appeal, however, did not challenge the district court’s analysis regarding the scope of the underwriting and administering risk exception.\(^{97}\) Rather, it sought to overturn the district court finding that the wellness program was a “term” of the County’s health plan.\(^{98}\) The 11th Circuit rejected

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91. *Id.* at 1019.
92. *Id.* at 1020.
94. *Id.*
96. *Id.*
98. *Id.*
the plaintiff's arguments on this point and found that the wellness program was, in fact, a term of the County's health plan. The 11th Circuit did not, however, address the district court's reasoning on the application of the safe harbor.

Seff is one case from one circuit so it is difficult to draw broad conclusions about its impact. Obviously, if the district court analysis in Seff is widely accepted then the ADA restrictions will not be a factor for wellness programs. There are reasons to be skeptical about that outcome though. First, as is noted above, the ADA plainly contemplates the use of wellness programs. To the extent that a "safe harbor" is needed, the statute provides one with its exception for voluntary medical inquiries in response to employee health programs. The Seff reading of the insurance safe harbor would seem to read that provision out of the statute. Second, the broad reading of underwriting advocated by Seff is at odds with EEOC guidance on the insurance safe harbor. The interpretive appendix to the ADA regulations states that the insurance safe harbor "is a limited exception that is only applicable to those who establish, sponsor, observe or administer benefit plans,..." The safe harbor's purpose "is to permit the development and administration of benefit plans in accordance with the accepted principles of risk assessment." The district court analysis in Seff goes well beyond these principles.

That being said, wellness plan providers and employers will likely continue to test the theory in Seff. Only time will tell whether the courts adopt or reject it. For the purposes of this article, it will be assumed that the ADA insurance safe-harbor is not applicable as its application essentially moots the tension that this article attempts to frame. Readers should bear in mind that the adoption of the safe-harbor is a potential outcome though.

IV. FRAMING THE PROBLEM

We have four laws that, for the most part, speak to different

99. Id.
100. See id.
102. Id.
103. See 29 C.F.R. app. § 1630.16(f) (2013).
104. Id.
105. Id.
elements of wellness programs. ACA and HIPAA discuss how wellness programs with financial incentives conditioned on health factors can operate without violating HIPAA's provisions on nondiscrimination. The ADA and GINA address how employee health and wellness programs can gather medical information without violating each statute's general prohibition regarding the collection of medical information.

The question is whether these laws work as a coherent whole or whether there is an inherent tension in the standards they employ. The answer turns, in large part, on how one interprets the term "voluntary" in the ADA and GINA.

In order to operate effectively, wellness programs need access to medical information. This is true regardless of whether the program seeks medical information to alert participants to health risks, guide participants to preventive programs, or establish health goals.

The inquiries used to gather this information inevitably fall under the ADA/GINA prohibition on involuntary medical exams and inquiries. If one believes that the presence of a penalty or reward that meets the ACA and HIPAA standards does not impact the voluntariness of a program, then there is no tension. The laws work in perfect harmony. If, however, one believes that financial inducements can render submission of medical information to a wellness program involuntary, then there is significant tension and a solution to that tension must be found.

107. See supra notes 64-68 and accompanying text.
108. See Berry, supra note 4, at 109.
109. See id. at 108-09.
110. Readers will also recall that the ADA provides an exemption for inquiries that are job-related and consistent with business necessity. Informal discussion letters from the EEOC's Office of Legal Counsel have consistently found that wellness programs are not job-related and consistent with business necessity and there is not much argument about that point. Wellness programs are in no way related to the performance of a job. See OFFICE OF LEGAL COUNSEL, EEOC, DISCUSSION LETTER ON HEALTH RISK ASSESSMENT AND THE ADA (2009), available at http://www.eeoc.gov/eeoc/foia/letters/2009/ada_health_risk_assessment.html (stating that the completion of HRAs "[d]o not appear to be job-related and consistent with business necessity . . . [b]ecause all employees are required to complete a health risk assessment . . . [and] there is no indication that your client has concerns that a particular employee will be unable to do his job or will pose a direct threat because of a medical condition."); see also OFFICE OF LEGAL COUNSEL, EEOC, ADA: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS; HEALTH RISK ASSESSMENT (2009) available at http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html (noting that HRAs that do not appear to be job-related and consistent with business necessity would violate the ADA).
The argument in support of harmony maintains that each law is ultimately concerned with the same thing—coercion. The ADA and GINA prevent covered entities from forcing employees to provide medical information. Similarly, the incentive standards in the ACA and HIPAA are, as the 2006 HIPAA regulation stated, designed so that permitted incentives are not “so large as to have the effect of denying coverage or creating too heavy a financial penalty on individuals who do not satisfy an initial wellness program standard.” Congress and the Secretaries of Labor, Health and Human Services, and Treasury have determined that inducements up to thirty percent of the employee cost of coverage (and fifty percent for programs aimed at smoking cessation) do not cross this threshold. According to this theory, if these programs are not coercive under ACA and HIPAA then they must also be not coercive, or voluntary, under the ADA and GINA. Therefore, there is no tension. A wellness plan that works for ACA/HIPAA should work for the ADA/GINA.

The argument against harmony employs different logic. It states that voluntary under the ADA/GINA means essentially what the EEOC said it meant in its enforcement guidance—a program cannot require participation or penalize employees who fail to participate. And, if

111. 29 C.F.R. § 1635.8 (2013); See supra note 110 and accompanying text.
114. And, as supporters of this theory would note, the EEOC at one point did say that a wellness program would be voluntary if it complied with the ACA and HIPPA standards. A January 6, 2009 informal discussion letter from then Legal Counsel Reed Russell stated that:
[A] wellness program would be considered voluntary and any disability-related inquiries or medical examinations conducted in connection with it would not violate the ADA, as long as the inducement to participate in the program did not exceed twenty percent of the cost of employee only or employee and dependent coverage under the plan, consistent with regulations promulgated pursuant to the Health Insurance Portability and Accountability Act.


That portion of the letter was subsequently overturned in March 9, 2009 letter from Legal Counsel Peggy Mastroianni. The justification was that the letter prompting Legal Counsel Reed’s reply had not asked for an opinion about acceptable inducement levels under the ADA. See OFFICE OF LEGAL COUNSEL, EEOC, ADA: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS; HEALTH RISK ASSESSMENT (2009) available at http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.

115. Enforcement Guidance: Disability Related Inquiries and Medical Examinations of Employees under the Americans with Disabilities Act, EEOC 15 (July 27, 2000),
one applies that definition strictly, no program that offers incentives for health information—regardless of whether those incentives are for information used in a "participatory program" or "health contingent program" as defined in the ACA and HIPAA—is voluntary. The use of incentives will inevitably penalize employees who decline to participate (as the incentive is withheld from them) or, if the inducements approach the maximum levels sanctioned by the ACA and HIPAA, amount to a requirement to participate through the imposition of unsustainable costs on those who opt-out. As a result, there is a great deal of tension between these laws.

The solution to this tension depends heavily upon how one frames the conflict between the laws. The first option is to frame it as the functional equivalent of a direct statutory conflict. We are presented with two sets of statute that deal with similar issues. The terms in one group appear to implicitly prohibit or, at the least, severely constrain programs permitted by the other group. It seems fair to say that whatever Congress said was permitted in the last statute (here the ACA) should govern what is permitted under the other statutes.

The second option is to accept the tension as a result intended by Congress. It is true that the laws deal with similar broad themes. But, at a granular level, they confront different problems. HIPAA and the ACA deal with the ways in which group plans and providers can vary rates and premiums on the basis of health factors such as disability and genetic information. GINA and the ADA are concerned with the circumstances under which a person can be compelled to provide that information. It is conceivable that Congress would impose different standards for each of these areas. Further, Congress had the chance to explicitly declare that the methods permitted under HIPAA should be permitted under the ADA and GINA as well but it failed to do so.

The amendments in the ACA are only applicable to the section amended—they do not apply "notwithstanding any provision of law." The only solution is to craft a nuanced policy that reflects the inherent tension.

It is beyond the scope of this article to say whether the arguments for or against tension are correct or, if one accepts that there is tension,
whether we are presented with the equivalent of a direct conflict or not. The courts, the relevant administrative agencies, and possibly Congress will need to arrive at the conclusion.

The manner in which the relevant actors choose to view the problem will have a sizeable impact on the solution that is developed though. For, if there is no tension, then there is no problem that needs to be resolved. A statement from an administrative agency or court that no tension exists is all that is required to put uncertainty to rest. But, if there is tension, then a court, administrative agency, or potentially Congress has to take steps to resolve that tension. If one believes that the tension is the result of a direct conflict in law, then the answer is simple—the last set of standards passed is acceptable under the older statutes. If one believes that the tension is intended, however, and that Congress appears to have wanted both sets of rules to apply—in spite of the policy conflict that creates—then a more nuanced answer is required. Only time will tell which policy outcome will prevail.

V. CONCLUSION

The jumble of standards that apply to wellness programs presents an interesting dilemma. Through its own actions, and in some cases inaction, Congress has developed a system of rules that could conflict on a practical level. It is now up to the courts, the administrative agencies, and potentially Congress, to decide whether a conflict exists and, if so, determine the appropriate resolution to that conflict.

This article has sought to explore the various ways one can frame this conflict. It does this on the theory that the manner in which one frames the problem will have a heavy influence on the ultimate solution that is developed. Though a firm conclusion regarding which frame should be used in crafting the solution is beyond the scope of this article, it is hoped that clarifying the frames will allow others to make coherent arguments about what the appropriate solution will look like.