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EMPLOYER WELLNESS INCENTIVES, THE ACA, AND THE ADA: RECONCILING POLICY OBJECTIVES

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Can employer-sponsored wellness programs promote health without discriminating against individuals on the basis of their health? The answer to this question surely must be yes. Employers that increase the availability of healthy food to their employees, provide health information, or support physical activity help build a foundation for healthy living. The fact that employers can promote health, however, does not mean that they do promote health, that they promote health equally for all employees, or that their interventions achieve success in improving health status. Much will necessarily depend on employer wellness program design, employee engagement, and the characteristics of the employee population.

As legal scholars have recognized, numerous state and federal laws and regulations shape the design of wellness programs, particularly programs that rely on financial incentives.[1] *Much of the substantive exploration of legal limits for these programs has focused on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), its regulations, and the closely related provisions in the Patient Protection and Affordable Care Act of 2010 (ACA). This now relatively well-defined regulatory regime aims to facilitate the use of financial incentives to promote health, while precluding discrimination based on health status in group health plans. Attention has now turned to an overlapping but distinct worry about wellness*

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1. *See, e.g.*, Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination — The Legal Limits*, 359 NEW ENG. J. MED. 192 (2008).

programs: the possibility that these programs might discriminate against individuals based on disability.[2]

This concern is not new. It has probably existed since the advent of wellness programs, and policymakers have long made clear the possibility that wellness incentives might run afoul of a variety of laws targeting discrimination. Against this backdrop, it is no surprise that employers have long sought to determine the relevance of these laws to their wellness programs. Legal scholars have started exploring the implications of statutes such as the Americans with Disabilities Act of 1990 (ADA), as amended, and the Genetic Information Nondiscrimination Act of 2008 (GINA).[3]

What is new, however, is that federal regulators are now taking steps that are likely to clarify how some of these antidiscrimination statutes apply to wellness programs. In 2014, the Equal Employment Opportunity Commission (EEOC) filed suit against a large employer, alleging that its wellness program violated both the ADA and GINA.[4] *In 2015, the EEOC issued a proposed rule under the ADA that has the potential to influence the design of future wellness programs and create a platform for broader discussion about employers' roles in health promotion, the desirability of the use of financial levers to influence behavior, and the risks that current practices may pose for individuals with disabilities.*[5]

At the heart of the proposed rule is the following question: Under what circumstances is an employer permitted to make disability-related inquiries or conduct medical examinations? When the ADA was enacted, Congress sought to limit disability-related stigma and discrimination by prohibiting such inquiries and examinations unless they are job-related and consistent with business necessity.[6] *Recognizing that wellness programs might incorporate inquiries or examinations that would run afoul of this prohibition, Congress created an exception for "voluntary medical examinations,*

2. *See, e.g.*, E. Pierce Blue, *Wellness Programs, the ADA, and GINA: Framing the Conflict*, 31 HOFSTRA LAB. & EMP. L.J. 357 (2014).

3. *See, e.g.*, *id.*; *see also* Jennifer S. Bard, *When Public Health and Genetic Privacy Collide: Positive and Normative Theories Explaining How ACA's Expansion of Corporate Wellness Programs Conflicts with GINA's Privacy Rules*, 309 J.L. MED. & ETHICS 469 (2011); Mark A. Rothstein & Heather L. Harrell, *Health Risk Reduction Programs in Employer-Sponsored Health Plans: Part II-Law and Ethics*, 51 J. OC-13.3(l4(6h.-(ramPA.-(ramg1(m)-2.9)7 20406(0(TH)-4(L.6( )]TJ0 Tc 8.5

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including voluntary medical histories, which are part of an employee

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Part I of this essay discusses the pre-ADA, pre-HIPAA origins of wellness programs, describes their current configurations, and presents evidence of their impact. Part II lays out the HIPAA–ACA regulatory framework that applies to wellness incentives and then explores its implications. Part III examines the relationship between disability and wellness, and then considers how the ADA might apply to wellness incentives, highlighting longstanding legal uncertainties surrounding this question. It details developments in the past year that are relevant to the debate, and concludes with a description of key incentive provisions in the EEOC's April 2015 proposed rule. Part IV offers an analysis of the proposed rule's incentive ceiling in light of the differing objectives of the ACA and the ADA. After exploring what the ADA's requirement for voluntariness might mean in a general sense, it considers its implications for questions related to the incentive ceiling design, such as whether the ceiling should be adjusted when incentives are offered to family members, and whether the ceiling should apply to incentives offered outside of health plans. Part V concludes with a brief discussion of the broader concerns involving wellness programs, and a call for evidence-based regulation.

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stress management.[14] Smoking cessation programs, offered by more than a third of all surveyed employers, were the most common type of wellness activity.[15] By the end of the 1980s, many well-known corporations had adopted wellness programs, including Honeywell, Safeway, Sara Lee, AT&T, Johnson & Johnson, Lockheed, IBM, and Kimberly-Clark.[16]

This early growth of workplace wellness programs was supported by federal policymakers. The federal government sponsored a national conference on health promotion programs in occupational settings in 1979.[17] By 1989, the U.S. Office of Disease Prevention and Health Promotion was developing a clearinghouse to make information on health programs accessible to small companies.[18]

Today a similar role is played by the Centers for Disease Control and Prevention, which provides information and planning tools,[19] and operates the National Healthy Worksite Program.[20] Some state governments have supported the development of wellness programs through tax credits and other programs.[21] There are also now countless nonprofit organizations and for-profit consultants, employee benefits companies, and other organizations thultatnes(68n(Officeons an)11.1w8oea)6.9(s)14.4(e)6sp

Kaiser Family Foundation survey of employers found that nearly three-quarters of all firms offering health benefits, and nearly all firms with 200 or more workers offering health benefits, offered at least one common type of wellness program.[23] While wellness programs can vary significantly in both structure and scope, many share common elements. For example, nearly two-thirds of large employers offered smoking cessation programs, nearly sixty percent offered lifestyle or behavioral coaching, and just under half offered weight-loss programs.[24] Just over half of large firms offered health risk assessments (HRAs), which typically involve a questionnaire that elicits information about an individual's health and health-related behaviors.[25] The HRA can then be used to evaluate the respondent's health risks.[26] A similar number offered biometric-screening programs for risk factors such as cholesterol or blood pressure.[27] Given that large firms account for more than half of U.S.

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of gift cards, cash, or rewards such as travel or merchandise, while 14% offer insurance premium discounts, and about 8% offer higher contributions to health reimbursement or health savings accounts.[36] About 12% of large firms offer incentives for completing their wellness programs, and about 32% of these firms offer incentives of at least $500.[37] About 51% of large firms that offer HRAs provide financial incentives for their completion, and of these firms, about 36% offer incentives of $500 or more.[38]

Some incentive programs target not only HRA completion and program participation, but also smoking status and biometric outcomes such as blood pressure or body mass index. The Kaiser Family Foundation survey found that of the large firms surveyed that offered biometric screening, 8% reward or penalize employees based on screening results (other than those related to smoking).[39] A 2013–2014 survey completed by very large employers collectively employing more than 11 million individuals found that more than 40% of these employers rewarded nonsmokers or penalized smokers with an annual incentivers or plme(rsD[(wic)7.1(40.1333 T4)12(tivei2v2910.8rde1(l)-26 Tw 516

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Randomized controlled trials demonstrate that appropriately structured financial incentives can help individuals achieve health goals such as quitting smoking or losing weight, but there is a need for more evidence on the impact of health plan-based wellness incentives such as premium adjustments.[44]

The limited information available about the impact of wellness incentives is especially troubling in light of the potential concerns that incentive-based programs may raise. Incentives that improve health, increase productivity, and reduce health care costs could help both employers and employees; if net gains exist and are shared through premium reductions, benefit enhancements, or wage increases, they could even benefit employees who do not respond to the incentives. At the same time, incentive-based programs offer no health benefits to, and can impose significant financial burdens on, employees who do not engage in the targeted activities or who fail to achieve the targeted outcomes. These burdens will fall particularly heavily on low-income individuals, and will tend to fall disproportionately on those who face health-related or other barriers to program engagement. The tensions inherent in wellness incentives—their potential for generating health-related benefits and burdens simultaneously—pose challenges for regulators trying to achieve a complex mix of policy objectives.

II. FEDERAL REGULATION UNDER HIPAA AND THE ACA

There is no federal statute that imposes a broad ban on discrimination on the basis of health. Instead, more narrowly focusecusdens (1.4R11.7(v -15.989)-1

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that the programs were offered, not on the financial incentives embedded within them. This suggests that such incentives were not

Most of the ACA's provisions mirror the HIPAA regulations.[59] The ACA permits premium discounts, premium surcharges, and other plan-based, health status-related incentives for programs that are "reasonably designed to promote health or prevent disease" and are "not a subterfuge for discriminating based on a health status factor."[60] The rewards must be offered annually,[61] and must be available to all similarly situated individuals.[62] Programs must grant a waiver or recognize a reasonable alternative standard for individuals for whom "it is unreasonably difficult due to a medical condition to satisfy" or "medically inadvisable to attempt to satisfy" a wellness program standard.[63] All plan materials describing the wellness program must disclose the availability of the reasonable alternative standard or waiver.[64] Regulations issued in 2013 sought to increase the likelihood that health-contingent wellness programs supported enrollees in their efforts to improve health, rather than merely shifting costs to higher risk individuals,[65] by clarifying what constitutes a reasonable alternative standard.[66] Several provisions were aimed at limiting the burden on individuals invoking such standards. For example, a provision requires employers to assist in identifying a program that would satisfy the standard and mandated that any time commitment involved be reasonable.[67]

One respect in which the ACA's requirements deviated from HIPAA's requirements was in the permissible magnitude of incentives. Policymakers decided to reaffirm their commitment to incentive-based wellness programs by raising the ceiling on health-contingent incentives from 20% to 30% of the cost of coverage, while

59. Affordable Care Act § 1201, codified at 42 U.S.C. § 300gg-4(j) (2010). For a discussion of these rules, see Kristin M. Madison, Kevin G. Volpp, and Scott D. Halpern, *The Law, Policy, and Ethics of Employers' Use of Financial Incentives to Improve Health*, 39 J.L. MED. & ETHICS. 450, 461–63 (2011) (discussing the ACA's limits on wellness programs). *See also* Lindsay F. Wiley,

giving regulators the authority to further increase the limit to 50%.[68] Regulators decided to leave the 30% ceiling in place for wellness programs in general, but permitted plans to increase this ceiling "by an additional 20 percentage points (to 50 percent), to the extent that

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training, and other terms, conditions, and privileges of employment."[78] Workplace wellness programs are therefore subject to the ADA's reach.

A. Individuals with Disabilities in an Era of Workplace Wellness

Individuals with disabilities can benefit from workplace wellness programs. Having a "physical or mental impairment that substantially limits one or more major life activities" might not preclude participation in a walking program, meeting a blood pressure target, or quitting smoking,[79] and engagement with wellness programs that include these elements might improve individuals' health. *The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities*, a 2005 report, emphasized that "[p]ersons with disabilities can promote their own good health by developing and maintaining healthy lifestyles."[80] Federal agencies have promoted the inclusion of individuals with disabilities in worksite wellness programs and have commissioned research on the topic.[81] To the extent that wellness programs are viewed as a toolkit that empowers individuals[82] by supporting their efforts to improve their own health, wellness programs can benefit individuals with disabilities just as they benefit individuals without disabilities.

Wellness programs are not always viewed as empowering, however. One scholar has suggested that the focus on individual responsibility for health "creates new 'health deviants' and

78. *See* 42 U.S.C. § 12111(2) (2013) (defining "covered entity"); *id.* § 12111(5) (defining "employer"); *id.* § 12112(a).

79. According to 42 U.S.C. § 12102, "[t]he term 'disability' means, with respect to an individual (A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment (as described in paragraph (3))."

80. U.S. DEP'T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO IMPROVE THE HEALTH AND WELLNESS OF PERSONS WITH DISABILITIES 21 (2005), *available at* http://www.ncbi.nlm.nih.gov/books/NBK44667/pdf/Bookshelf_NBK44667.pdf.

81. OFFICE OF DISABILITY EMP'T POLICY, U.S. DEP'T OF LABOR, *RETAINING EMPLOYEES IN YOUR WORKSITE WELLNESS PROGRAM* 5 (2009), *available at* http://www.dol.gov/odep/research/WellnessToolkit.pdf; CATHERINE CALL, ROBYN GERDEN & KRISTEN ROBINSON, *HEALTH & WELLNESS RESEARCH STUDY: CORPORATE AND WORKSITE WELLNESS PROGRAMS: A RESEARCH REVIEW FOCUSED ON INDIVIDUALS WITH DISABILITIES* 6 (2009), *available at* http://www.dol.gov/odep/research/CorporateWellnessResearchLiteratureReview.pdf.

82. *See* Conrad, *supra* note 9, at 264 (discussing the potential for individual empowerment within the context of wellness programs).

easily access other individuals' data.[88] Given the risks that wellness programs can introduce into the workplace, the ADA provides important protections for individuals exposed to these programs.

B. The Americans with Disabilities Act

The broad reach of the ADA in the employment context ensures its applicability to wellness programs. For example, the ADA reinforces the ACA reasonable alternative standard rules in the disability context by requiring employers to provide reasonable accommodations that would allow employees with disabilities to take full advantage of employee wellness programs, including the opportunities to earn rewards or avoid penalties.[89] In some cases, obligations under the ADA extend beyond those of the ACA. For example, in recently proposed regulations the EEOC points out that an employer offering an incentive to attend a nutrition class "would have to provide a sign language interpreter so that an employee who is deaf and needs an interpreter to understand the information communicated in the class could earn the incentive, as long as providing the interpreter would not result in undue hardship to the employer."[90] Such a requirement would seem to be a relatively TD[(commu)13.2iAsA20.607

required for participation in a particular employer benefit program? Is a medical history voluntary if an employee is financially rewarded for completing it? What if an employee is subject to an insurance premium surcharge if the employee refuses to complete a questionnaire? As Part I makes clear, at the time the ADA was enacted, financial incentives had already begun to find their way into health programs. The extent to which these incentives were associated with disability-related questionnaires or medical examinations is much less clear, however, and neither the ADA nor the House Report references the use of incentives.

In 2000, the EEOC issued enforcement guidance that clarified that employers can make disability-related inquiries or conduct medical examinations as part of a voluntary wellness program if "medical records acquired as part of the wellness program are kept confidential and separate from personnel records."[97] It further explained that a "wellness program is 'voluntary' as long as an employer neither requires participation nor penalizes employees who do not participate."[98] It gave no further clarification, however, of the kinds of sanctions that would render the program involuntary. For example, would a failure to earn a reward constitute an impermissible penalty? And does the answer to this question depend on the size of the reward?

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regulations.[101] Two months later, however, EEOC legal counsel rescinded this portion of the letter, explaining that its correspondent's initial inquiry had not asked about permissible levels of inducement, and that the "Commission is continuing to examine" the question.[102]

The EEOC was apparently still continuing to examine the question over a year later, as it had not yet issued any formal guidance answering the question when it addressed a similar question under a different antidiscrimination statute, the Genetic Information Nondiscrimination Act (GINA).[103] The statute made it unlawful for an employer to request genetic information with respect to an employee or an employee's family member, but provided an exception for "health or genetic services" that "are offered by the employer, including such services offered as part of a wellness program" where "the employee provides prior, knowing, voluntary, and written authorization."[104] In promulgating final regulations under GINA in 2010, the EEOC restricted the applicability of the exception to situations where "[t]he provision of genetic information by the individual is voluntary, meaning the covered entity neither requires the individual to provide genetic information nor penalizes those who choose not to provide it."[105] The regulations subsequently state that employers can offer inducements to complete HRAs that request genetic information, "provided that the covered entity makes clear . . . that the inducement will be made available whether or not the participant answers questions regarding genetic information."[106] In short, no incentives may be offered with respect to genetic information, an approach quite different from the one suggested in the retracted portion of the 2009 letter.[107]

In 2013, the Department of Treasury, the Department of Labor, and the Department of Health and Human Services released the final regulations governing wellness programs under the ACA.[108] The ACA promoted growth in wellness incentives in many ways; in

101. *Id.*

102. *Id.*

103. Regulations Under the Genetic Information Nondiscrimination Act of 2008, 75 Fed. Reg. 68,911 (Nov. 9, 2010) (to be codified at 29 C.F.R. pt. 1635).

104. 42 U.S.C. § 2000ff-1(b) (2008).

105. 29 C.F.R. §1635.8(b)(2)(i) (2011).

106. *Id.*

107. For a discussion of the tensions between wellness programs and genetic privacy, as well as an overview of the GINA regulations, see generally Bard, *supra* note 3.

108. Incentives for Nondiscriminatory Wellness Programs, *supra* note 65.

addition to lifting the wellness incentive ceiling, the ACA called for information to be gathered on wellness programs and mandated wellness demonstration projects within both Medicaid and the individual insurance marketplace.[109] Some employers might have been reluctant to adopt wellness programs, however, given the

examination under the ADA that was not job-related or consistent with business necessity, that Honeywell "imposes a penalty upon employees to make them participate," that the testing was not voluntary, and that the exam was an unlawful medical examination in violation of the ADA.[115]

The reaction from the business community was swift. Within a few days after the court filing, the ERISA Industry Council (ERIC), an organization "advocating for the employee benefit and compensation interests of the country's largest employers,"[116] called the suit an "outrageous development," expressed concern "that it apparently is no longer enough for an employer-sponsored wellness plan to comply with the applicable requirements under the Affordable Care Act," and noted that ERIC ha

Honeywell.[121]

The court ruling did not end discussions of wellness programs and the potential impact of the ADA, however. In January 2015, the U.S. Senate Committee on Health, Education, Labor & Pensions held a committee hearing titled "Employer Wellness Programs: Better Health Outcomes and Lower Costs."[122] In March 2015, the "Preserving Employee Wellness Programs Act" was introduced into Congress. Section 3(a) of the Act states that:

> Notwithstanding any other provision of law, workplace wellness programs, or programs of health promotion or disease prevention offered by an employer or in conjunction with an employer-sponsored health plan . . . shall not violate the Americans with Disabilities Act of 1990 . . . because such program provides any amount or type of reward . . . to program participants if such program complies with such section 2705(j) (or any reg.nov7.001 Tc 0

related to medical examinations on employees," or if it "exists mainly to shift costs from the covered entity to targeted employees based on their health."[126]

ADA incentive rules.[132] The applicability of the proposed rule's incentive limits to rewards or penalties based on tobacco use would therefore depend on the mechanism for determining use. A reward contingent on a negative result on a biometric screening for nicotine would be subject to the ADA limit of thirty percent. By contrast, a reward contingent on a negative answer to a question about nicotine use would not be subject to the ADA limit, assuming that the question is not a disability-related inquiry.[133]

D. The ADA, the ACA, and Wellness Programs: Acknowledging the Policy Tensions

The events over the past year highlight the tensions inherent in policymakers' efforts to achieve multiple goals simultaneously. HIPAA and the ACA reflect a desire to increase access to affordable health insurance by curtailing health status-based insurance discrimination.[134] The HIPAA–ACA wellness program exceptions reflect a willingness to limit the reach of antidiscrimination principles in order to support employer wellness programs that have long been touted as tools for improving health, containing costs, increasing morale, and boosting productivity.[135] The ADA's limit on disability-related inquiries and medical examinations reflects a goal of combating disability-related stigma in the workplace against the backdrop of a larger aim of promoting equality of opportunity and economic self-sufficiency by prohibiting disability-based discrimination.[136]

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occupational advancement, these activities would fall within the purview of accepted activities."[152] The ADA thus provides an exception to the general prohibition on disability-related inquiries and examinations for "voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."[153]

The EEOC's task in the ADA rulemaking, then, is to determine the circumstances under which incentives would render medical examinations or medical histories involuntary. As detailed in Part III, the EEOC previously offered views on this question in the form of

while the most commonly cited reasons for declining participation in wellness programs were time constraints and a belief that the program was not needed to make changes,[156] about 13% cited as a major reason a worry "that [their] employer will know [their] personal health information," and another 20% cited such worries as a minor reason.[157]

If the trouble with mandatory participation is that it leads individuals to reveal information that they would not otherwise reveal, should incentives that encourage information revelation also be deemed to render wellness program participation involuntary? After all, an employer denied the ability to mandate participation

undermines voluntariness. In the comment it submitted to the EEOC, the Bazelon Center noted the EEOC's earlier position that voluntariness precluded penalties and pointed to dictionary definitions that emphasized the absence of "valuable consideration" as an element of voluntariness.[161] The weakness in a dictionary-based argument is that dictionaries often offer multiple definitions. While the Merriam-Webster Dictionary defines "voluntary" to include "acting or done of one's own free will without valuable consideration or legal obligation," another definition is "proceeding from the will or from one's own choice or consent."[162] Consider an individual who chooses to work for an employer that offers a good salary, but would not volunteer to work for the employer for free. Does the salary make the individual's decision to work for the employer involuntary? Would the individual's unwillingness to volunteer suffice to establish that the individual's decision was involuntary? It seems reasonable to conclude that incentives can sometimes be compatible with voluntariness.

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inducements.

When incentives function as penalties, they might be viewed as undermining voluntariness by being "coercive." Scholarly definitions of coercion vary, but they generally reflect the principle that incentives can coerce only if they worsen an individual's situation or violate an individual's rights.[169] The notion of individual rights is not especially helpful in this context, since the nature of these rights remains to be defined; the EEOC must settle upon a definition of voluntariness before it can determine employers' obligations toward their employees. The more easily supported claim is that wellness incentives might worsen employees' situations. Some scholars have said that to be coercive, penalties must threaten "severe" harm or leave an individual with "no reasonable alternative."[170]

It is difficult to attach specific numbers to these very general characterizations. Could the failure to obtain a $500 reward for completing an HRA appropriately be described as a "severe" harm (if it is to be characterized as a harm at all), or one that leaves someone with "no reasonable alternative"? What about a $500 premium surcharge for tobacco users directed at someone who refuses to take a cotinine test? If these harms do seem severe with respect to individual employees, do we need to consider whether incentive programs in general are successful at reducing employee health care costs or boosting overall productivity, and, if so, whether gains are shared with workers in the form of lower premiums or higher pay? In that case, indirect benefits to the employee may offset some of the direct harms experienced through refusing to participate.[171] Determining a baseline against which to measure an employee's harm is conceptually difficult in a setting in which the employer plays a role in defining all of the terms and conditions of employment, including the terms of a benefit plan.[172]

B. An Incentive Ceiling Based on the Cost of Coverage?

Regardless of the theoretical complexities, the idea that incentives can be so large as to be problematic is clearly reflected in regulators' decisions. It may be difficult to determine the appropriate lines to draw, but regulators draw them. Under the ACA, regulators

169. *See* Madison, Volpp & Halpern, *supra* note 59, at 459–60.

170. *Id.*

171. See *id.* for a numerical example.

172. *See id.*

use.[179] If the assumption is that regulators would not allow for coercive health incentives, then it makes as much sense to use the 50% ceiling as to use the 30% ceiling. While some might view the

thus limiting the pressure on individuals to reveal disability-related information. The ceiling should generally apply to incentives tied to HRA completion as well as to any participation-, activity-, or outcome-based incentives available only to individuals who answer disability-related questions or undergo medical examinations.

The proposed rule appears to deviate from this approach in a few ways. For example, it might be read to include some incentives that are not contingent on inquiries or examinations. Consider the language of the proposed regulation:

> The use of incentives . . . together with the reward for any other wellness program that is offered as part of a group health plan . . .

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class, then it will not be subject to the ADA incentive rules, since no inquiry or examination is involved. But if the program also ties $500 to an HRA, should the $50 be added to the $500 for purposes of determining whether program incentives render the program involuntary?

Several organizations have submitted comments suggesting that this rule applies too broadly to participatory programs, or that its

There are at least two alternatives to including family incentives in the aggregate, but not in the ceiling. The first alternative is to exclude family incentives from both the aggregate and the ceiling. In other words, the employee-only ceiling could remain in place, but the proposed rule could be clarified or revised to ensure that incentives directed at individuals other than the employee are disregarded in a voluntariness analysis. A second alternative is to include family incentives in both the aggregate and the ceiling. This is the approach the ACA takes in defining the wellness program exception to health plan nondiscrimination rules: the ACA ceiling applies to the "cost of coverage in which an employee or individual and any dependents are enrolled" when "any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program."[193] A number of commenters representing employers have argued that the ADA should similarly use the cost of family coverage as the baseline when the calculation includes incentives offered to family members.[194]

In the ACA context, extending wellness programs' incentive ceiling to dependents is consistent with the structure of the nondiscrimination rules as well as the wellness exception. The health plan antidiscrimination provisions expressly apply both to enrolled individuals and their enrolled dependents.[195] If the primary goal of the wellness program regulations is to promote health for all enrolled individuals while pre

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disabilities of others.[198] By extension, then, inquiries about the disabilities of others could pose a risk for discrimination against an employee, and there is reason to consider the incentives offered for such inquiries.[199] The ACA's approach offers a mechanism for doing this; a calculation based on aggregate incentives and family coverage costs approximates the analysis that would be applied in the case of an individual employee. For example, if the cost of covering a family is $12,000 and employees and their spouses are each awarded $1,000 for HRA completion, the calculation would be equivalent to the situation in which the cost of individual coverage is $6,000 and the employee is awarded $1,000 for HRA completion.

Either of these two approaches—including family incentives in the pool and using a family coverage-based ceiling or omitting family incentives from consideration entirely—would give employers more room to offer incentives to employees' dependents through the health plan. Some might be concerned that both options extend employers' reach even further beyond the workplace than do employee-only incentives, but these options permit employers to try to promote wellness among family members. Providing incentives to family members might also reinforce employers' efforts to promote health among employees. Several commenters suggested that involving family members increases employees' engagement in wellness programs.[200]

E. Incentives Outside of Health Plans

Parts IV.C and D suggest two ways in which the proposed rule could be viewed as overinclusive: If the employee-only coverage cost

198. *See* Mark A. Rothstein, *Innovations of the Americans with Disabilities Act: Confronting Disability Discrimination in Employment*, 313 JAMA 2221, 2221 (2015) (discussing associational discrimination in the context of the ADA).

should not be either. If regulators are concerned that high levels of incentives might undermine the voluntariness of wellness programs, there seems to be little reason to distinguish between dollars offered inside health plans and dollars offered outside health plans.

This raises the question of why the EEOC has chosen to focus on health plans in the first place. One possible answer is that the EEOC was under pressure to respond to employers who protested the possibility that ACA-compliant programs might run afoul of the ADA. Because the relevant ACA provisions targeted wellness programs that might otherwise violate provisions prohibiting discrimination in health plans, the EEOC's attention was drawn specifically to plan-based incentives. The EEOC's silence on incentives outside of health plans leaves unanswered questions about the extent to which such incentives could render a wellness program involuntary.

Some might argue that such incentives should be disallowed in their entirety, while others might argue that they should be permitted without restriction. Indeed, such leunt une-3.5Tc 0.6338 4(ol)-42084 o9i 1cenres4(25 Td[(s)-6 o)p

contribution they must pay to obtain health insurance. But at some point, perhaps the incentive could become sufficiently large so as to raise concerns. A ceiling would mitigate this risk.

Determining a ceiling outside of the health plan setting presents a practical challenge. In some cases, employees will be enrolled in health plans, and for these employees it seems appropriate to incorporate non-health plan-based incentives into the standard cost-of-coverage formula. If the role of the cost-of-coverage denominator is to define a reasonable limit on the total magnitude of incentives, then it seems not just appropriate, but indeed necessary, to aggregate all wellness-program incentives together, regardless of their origins.

For employees who are not enrolled in health plans, however, a.

Congress has chosen to create, regulators must take into account the

instead focused narrowly on voluntariness, and it concludes that while the ACA regulation is not a perfect fit, neither is a prohibition on incentives.

If the question under consideration were, "How should wellness programs be regulated to ensure that they benefit individuals with disabilities?", or "How should wellness programs be regulated to shield individuals with disabilities from bearing unacceptable burdens?", then the focus of the analysis would need to be much broader. Indeed, the factors involved in such an analysis would bear a very close resemblance to those actually considered in the creation of the original HIPAA regulations. This is not surprising. After all, disability is one of the health factors subject to HIPAA's protections. Furthermore, because regulators sought to define an exception for "programs of health promotion andf he 3 0 2(e rpr11.4(eev11.7(ern)-42i)-1.9(on ,11.3(m224

different from saying that incentives that take the form typically used in wellness programs have a significant long-term impact on health, health costs, or productivity, and some studies cast doubt on or raise concerns about the benefits of wellness programs that have been adopted to date.[214] Much remains to be understood about how incentive programs function in practice, including how they impact individuals with disabilities. With more evidence, it may be possible to better tailor statutory and regulatory requirements to ensure that wellness programs are structured in ways that advance policy objectives, regardless of whether those objectives are currently embedded in the ACA, the ADA, the exceptions to these rules, or elsewhere.

As this article goes to press, st