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“Not Just Another Day at the Beach: Employer Wellness Programs Draw Fire”

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Introduction

Some link the “wellness concept” to the ancient Greek philosophy of “arête”, which promoted goodness, excellence or virtue generally of the mind, body and soul. Dr. Halbert L. Dunn (1896-1975), a biostatistician and the generally recognized “father of the wellness movement” in the U.S., established a concept of wellness in a series of lectures he gave at the Unitarian Church in Virginia in the late 1950’s. These lectures became the basis for his book, High Level of Wellness that was published in 1961. However, it was not until the mid-1970’s that the first wellness center was opened in the U.S. in Mill Valley, CA. Interestingly, the term “wellness” still did not appear in the Second Edition of Webster's New Unabridged Twentieth Century Dictionary that was published in 1983. Currently, the Wikipedia website for the term “wellness” indicates that is generally used to mean “a healthy balance of the mind, body and spirit that results in an overall feeling of well-being.”

The word “privacy”, which comes from the Latin term privatus, is a concept that is most often linked with Western culture, particularly English and North American cultures. It is by no means a universal concept and many languages do not have a translatable word for privacy.1 The first publication advocating privacy in the United States was authored by Samuel Warren and Louis Brandeis in 1890 largely in response to the increasing popularity of newspapers and photographs made possible by printing presses.2 As the term is used in this country to describe informational privacy, including information about one’s medical records, the concept of privacy is constantly evolving and taking on greater importance particularly as new technologies evolve creating more threats to the privacy of our health-related records.

Today the concept of wellness has become common place in the workplace through various employer/union – sponsored “wellness programs”. As more and more employers and unions agree to establish wellness programs3 for workers and their families, privacy concerns abound particularly about how participants’ sensitive health-related information is safeguarded. Participants also worry that their private medical information will be used in ways that will adversely affect their employment and health-care coverage. In addition, because so many different federal and state laws regulate various aspects of wellness programs in potentially conflicting or ambiguous ways, for lawyers who advise their clients on such issues, it can often turn that lovely day at the beach into one filled with torment – with sand fleas constantly nipping at their toes...and where they can’t jump into the water for relief because it’s filled with jellyfish.

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1 Wikipedia (the free internet encyclopedia).
3 When the term “wellness program” is used by some it often can include employee assistance programs (“EAPs”). This paper, however, focuses on wellness programs.
After laying out the financial imperatives for creating wellness programs, this paper will focus on the privacy issues as well as those other sometimes sticky legal issues that can be encountered (and hopefully overcome) in creating viable wellness programs.

Part 1 – Why Wellness Programs Are a Good Choice for Employers and Unions

There are many compelling reasons why wellness programs are a good option for employers, unions, workers and our nation. The employer, union and worker will save on health care expenditures over time. Many experts indicate that for every dollar one spends on wellness programs, $3.27 will be saved on future medical costs and that the costs of absenteeism will fall by about $2.73 for every dollar spent on such programs. Of equal importance, the health of most workers will be positively affected resulting in improved productivity at work and a longer healthier life expectancy.

A. The Financial Imperative

There are important cost considerations that are raised in adopting wellness programs. Conversely, there are even more compelling cost considerations in not adopting such programs.

1. Costs to the country, the employer, union and worker

The United States spends 42% more on health care of any industrialized nation while ranking 72nd, second to last, in quality of health care delivered. Almost 70% of healthcare costs are attributable to illnesses that are preventable. Clearly, if the U.S. wishes to maintain or improve its competitive status in the world economy, it needs to employ a number of strategies in controlling health care costs. Wellness programs are but one of those strategies that can be utilized to bring down health care costs. While there are a number of payors in our health care system, including the federal and state governments, this portion of the discussion focuses primarily on employers’ and workers’ health care costs and what those combined costs imply for the entire economy of the United States.

In 1999 the average premiums and worker contributions for family health care coverage was $5,791, with employers paying $4,247 and workers paying $1,543 of that cost. In 2009 the average combined employer-paid premiums and worker contributions for such coverage was $13,375 with employers paying $9,860 and workers paying $3,515 of such

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4 Some unions have self-insured health plans that are totally self-funded, with no contributions from the employer. Others are funded in whole or part through collective bargaining with the employer. Therefore, such union health plans confront the same cost issues that employer-sponsored health plans do.


6 Abramson, M.D. J., Overdo$ed America, the Broken Promise of American Medicine, (Harper, 2005) 46-47.

costs. Over this ten year period the premiums paid by employers rose 131% while the worker contributions increased by 128%. This alarming increase was more than three times the rate that workers’ wages increased and four times the rate of inflation.

Although our spend on prescription drugs is a relatively small proportion of national health care expenditures (10% in 2006), it has been one of the fastest growing components of health care expenditures – $216.7 billion in 2006 – more than five times the $40.3 billion we spent in 1990. Amazingly, today, one quarter of all senior citizens aged 65 and over now takes 10-19 prescription drugs a day! It is not surprising, but it should be cause for alarm, that the U.S. Department of Health and Human Services (“HHS”) projects that our collective spend on prescription drugs alone will increase to $515.7 billion by 2017, a 138% increase over the cost of such drugs in 2006.

Increasingly, employers, unions and workers and their families are struggling with how to meet these ever-escalating health care costs. Indeed, these concerns are readily apparent as health-care spending has outpaced the rise in all other consumer spending by almost a factor of three since 1980, increasing to 18% of gross domestic products (“GDP”) in 2009. It is estimated that 80% of group health care costs are caused by 20% of covered participants who have conditions that are preventable with appropriate interventions, including changes in lifestyle, diet, exercise, etc. It is also estimated that chronic diseases, with smoking, physical inactivity and obesity being major contributors, cause 75% of the nation’s healthcare costs. Remarkably, out of the $2 trillion spent in the U.S. on healthcare, only 4 cents of every dollar is spent on prevention.

Like the red flags that warn of dangers on our beaches, the statistics cited above should serve as a warning to all of us, employers, unions, workers, baby boomers and those who follow them. If we fail to heed these signs and do not learn how to control our health care

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costs, we will all find ourselves adrift in an ocean of debt, overwhelmed by health care costs\(^{14}\) and losing our competitiveness in the world market. Clearly, none of us can afford to continue to pay these ever-increasing costs. There are proven cost-effective steps we can all take to control these alarming trends. Wellness programs are one of these steps.

Some employers have chosen not to deal proactively with the issue of escalating health care costs. Instead, they have focused solely on their bottom line by simply passing increased health care costs to their workers by increasing their co-pays or premiums, or, by eliminating health care coverage altogether\(^ {15} \) – measures, which in this writer’s opinion, are incredibly short-sighted and in the end detrimental to our nation’s overall productivity and health. A few other employers have chosen creative but somewhat risky measures to cut their escalating medical costs by giving their employees incentives, including cash payments or recuperative stays in resorts, to have non-emergency surgery performed in countries like India, Thailand or Singapore. This questionable new practice, called “medical tourism”,\(^ {16} \) is not likely to significantly reduce health care costs and could end up jeopardizing the health and even the life of the worker.

Other more enlightened employers, however, recognize the value in working with their unions and employees towards more creative solutions to trim health care costs. Indeed, according to The New England Journal of Medicine, in a national poll of employers, 91% believed they could reduce their health care costs by influencing employees to adopt healthier lifestyles\(^ {17} \). Increasingly, employers embrace wellness programs and often offer incentives to their employees for participating in them\(^ {18} \). Insurers too have eagerly embraced wellness programs by offering discounts on insurance premiums or co-pays and by lowering deductibles for employers and employees that adopt a variety of healthy lifestyle programs.\(^ {19} \)

Currently, more public sector employees have access to wellness programs (and employee assistance programs) than do private sector employees, largely because a greater percentage of public sector workers are represented by unions. This trend is beginning to show encouraging signs of growth in the private sector although the growth in the public sector continues to outpace that in the private sector.\(^ {20} \) From 1998 to 2008 access to

\(^{14}\) Before the current recession, a Harvard study indicated that medical costs were the number one cause of personal bankruptcy in the U.S., accounting for 62% of all personal bankruptcies in 2007. See Arnst, C., “Study Links Medical Costs and Personal Bankruptcy”, Business Week (June 4, 2009).\(^ {http://www.businessweek.com/bwdaily/dnflash/content/jun2009/db2009064_666715.htm}\).

\(^{15}\) According to The Kaiser Family Foundation, 21% of employers reduced health benefits or increased cost sharing due to the economic downturn (News Release, Sept. 15, 2009). \(^ {http://www.kff.org/insurance/ehbs091509nr.cfm}\).

\(^{16}\) N. Y. Times, Mar. 24, 2007 (Business Section).


\(^{18}\) Id. These incentives often take the form of prizes or cash rewards; less often, they take the form of financial penalties.

\(^{19}\) Id.

wellness (and employee assistance) programs increased from 35% to 54% for full-time public sector workers and from 19% to 28% for full-time private sector workers.21 There exist many stellar examples in both the public and private sectors of how carefully crafted and constantly evolving workplace wellness programs can reduce employer and employee health-care costs significantly while improving the overall health and productivity of the employee.22

2. The easy targets – obesity & smoking: guaranteed to generate savings in health care costs

Obesity and the associated diseases caused by it have become pandemic in our country. According to the Centers for Disease Control and Prevention ("CDC"), in 2008 only one state, Colorado, had a prevalence of obesity of less than 20% while thirty-two (32), states had a prevalence of equal to or greater than 25% of their total populations.23 Overall, our citizens, including our children,24 are now considered to be the most obese in the world. The national cost of obesity was estimated to be 9.1% of the total U.S. medical expenditure in 1998 for a total of $78.5 billion. In 2002 that cost soared to $92.6 billion. Between 1998 and 2006, obesity rates in the United States increased 37% so that today one in three adults are considered to be obese. The associated diseases caused by obesity now account for almost 10% of all our medical costs, with increased prescription drug costs being the largest of the cost drivers.25 In an updated study published last July on the Health Affairs website26 and presented at the U.S. Centers for Disease Control and Prevention Division of Nutrition, Physical Activity and Obesity’s Inaugural Conference on Obesity Prevention and Control in Washington, D.C. in July 2009, the medical costs of obesity had soared to $147 billion in 2008.

The diseases caused by smoking and second hand smoke are also a huge cost driver of medical expenses. According to the CDC, tobacco use is the nation’s leading killer. It is also the single most preventable cause of disease and disability.27 According to an article published in the New England Journal of Medicine in 1997, health care costs for smokers at

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21 Supra.
23 For example, since this conference is being held in California and since I am from New York, I note that the statistics from those two states indicate that in 2008 (20-24%) of the citizens of California and New York were considered to be obese.
24 CDC, The rate of obesity among children has more than doubled between 1976-1980 and 2003-2006. For those between ages 12-19 the prevalence increased from 5.0% to 17.6% over the same period of time.
26 Health Affairs website: http://content.healthaffairs.org/cgi/content/short/hlthaff.28.5w822 .
any given age were as much as 40% higher than those for nonsmokers. In 2009 the CDC tallied these direct health care costs at $96 billion. However, many who examine such health care costs fail to examine all the other economic factors that are adversely impacted by smoking. Smokers pay more for all types of insurance, not just health insurance. They lose money on the resale value of their homes and cars. They pay more for dry cleaning, etc. Employers overall prefer to hire nonsmokers and 1% of employers refuse to hire smokers. Current figures from the CDC indicate that smokers cost the economy $97.6 billion a year in lost productivity.

Based upon the statistics cited above, it seems obvious that the first targets of any wellness program should be obesity and smoking. These two health issues represent the “low hanging fruit” and are conditions/addictions over which the individual can exercise some control provided they are given appropriate support and incentives. In fact, many successful wellness programs have focused primarily on these two health issues in order to drive down health care costs and improve the overall health of the participants. However, more comprehensive wellness programs include promotion of good nutrition, fitness and exercise, lowering stress, disease prevention and detection, dealing with chronic illness and helping the addicted. Many employers and unions conduct employee surveys in order to help them gauge where the greatest interest is thereby ensuring better overall results through increased participation.

3. Types of Wellness Programs

There are different components of wellness programs that fundamentally fall into three general categories: (1) health risk assessments (which typically asks participants to record their medical histories, and sometimes that of their families, weight, height, whether they smoke and other lifestyle issues, etc.), (2) behavior modification programs (where often smoking cessation, weight loss programs are offered) and (3) disease management programs (longer term interventions for systemic diseases that can include “coaches”, who...

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28 These authors also observe that, if all smokers quit, health care costs would be lower in the beginning, but after 15 years they would be higher because the nonsmokers would be living longer. This type of analysis, labeled by some as an “elderly death credit”, has been heavily criticized as void against public policy. See Litigation Memorandum, State of Mississippi. Cited in Viscusi (2002, p.87). Indeed, Dr. Pechacek, the CDC’s Associate Director for Science in the Office on Smoking & Health, stated that if one followed the “natural train of logic that follows from that is that then anybody that’s admitted around age 65 or older that’s showing any signs of sickness should be denied treatment” because “that’s the cheapest thing to do.”

29 According a longitudinal study on the private and social cost of smoking by published in 2004, the personal cost of smoking to a 24-year old woman is $86,000 over her lifetime while such cost for a 24-year old man is $186,000. However, the total social cost of smoking over a lifetime, including the direct cost to the smoker as well as the costs imposed on others from second hand smoke, the cost of Medicare, Medicaid and Social Security such costs increase to $106,000 for each woman smoker and $220,000 for each male smoker. Sloan, F.A., Ostermann, J., et al., The Price of Smoking, The MIT Press (December 2004).

30 It has been reported that 40% of workers will have 3 or more health risks which individuals account for the majority of the employer’s health plan costs. See “Impact of ADA and ADEA on Wellness Program Design” (Oct. 7, 2005) http://jpmorgan.com/cm/cs?pagename=JPM_Coent/CA/Generic_Pa citing an article by Musich, M., et al. “Excess Healthcare Costs Associated with Excess Health Risks in Diseased and Non-diseased Health Risk Appraisal Participants” published by Disease Management Health Outcomes 2002;10 (4); 251-258.
sometimes are nurses, who will interact with a participant to ensure compliance with treatment regimens.) Employers and unions are free to design a program that can include one or of all of these components. Within these categories, there are many different subtle design elements, including, but not limited to, biometric testing, various incentives, personal health coaches, that can be embraced or not. The size, demographics and geographic location of the workforce are all factors that can affect how such a program is designed.

**Part II – Overcoming Obstacles to Wellness Programs**

There are, of course, some practical and legal issues that have to be addressed in designing and maintaining any effective wellness program. None of these issues are insurmountable.

**A. Practical Issues**

The practical issues that are raised in implementing any wellness program are typical to most such programs. Broadly, these issues include, but certainly are not limited to, (1) gauging need and interest in the program; (2) cost to implement and maintain the program; (3) measuring effectiveness of the program and; (4) liability issues.

1. **gauging need and interest in the program**

   The most effective way to guarantee positive results from establishing any wellness program is to first determine what health conditions/diseases in what segment of the workforce are costing the company and employee the most in health care costs, in lost time from work and in lost productivity.\(^{31}\) Next, it is critical to gauge employee interest in participating in such programs by conducting voluntary surveys.

2. **cost to implement and maintain the program**

   This factor is entirely dependant on the resources of the sponsor of the wellness program. Often the companies that make too small an initial investment in their wellness program doom it to failure.\(^{32}\) Smaller companies often struggle with the costs of offering any type of wellness program. Larger companies, like Johnson & Johnson, have seen a significant return on their investment (“ROI”). In 2002 they saw a $2.25 per employee per year reduction in health care costs and when they projected these saving out to 2007, they estimated a $400 per

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\(^{31}\) Bray, I., *Healthy Employees, Healthy Business* (Nolo, Oct. 2009), 24. Once savings are generated among high risk groups of employees through their participation in wellness programs, it is important not to overlook the potential for longer range savings by including employees in such programs who are in moderately good health. Establishing healthy lifestyles early on will avoid hefty health care costs down the road.

\(^{32}\) *Id.* at 19. Note also, Bray reports that incentives have been show to raise worker participation in wellness programs by as much as 23%, at 39.
employee per year cost savings. Obviously, the start up costs will not be recouped immediately. What those costs are will depend on how ambitious the plan is. For most, the first step should be to identify the low hanging fruit and to design the wellness program accordingly.

3. measuring effectiveness of the program

There are at least three major areas in which the success of any wellness program should be measured:

a) **Cost** – has the combined employer/worker cost of health care been affected by: (1) decreasing the actual cost of such care, (2) decreasing the rate by which such costs increase or, (3) flattening the cost of such care?

b) **Improved health of the worker** – have there been quantifiable improvements in measurable areas of the worker’s health thereby potentially extending the worker’s life expectancy?

c) **Improved productivity of the worker** – has the lowering of the worker’s health care costs and/or the improvement of the worker’s health decreased lost work days, increased worker productivity and contributed tangibility to the company’s success/competitiveness in measurable ways?

Rightly or wrongly, most measurements of the success of such programs focus exclusively or primarily on the cost factor. Predictably, in an influential article that appeared last June, the *Wall Street Journal* primarily focused on the cost factor in determining the efficacy of such programs. The *WSJ* stated “effective health-care reform must meet two objectives: 1) It must secure coverage for all Americans, and 2) it must dramatically lower the cost of health care.” The *WSJ* cited how health care spending had increased to 18% of our GDP in 2009. The *WSJ* went on to correctly observe that this “disturbing trend will not change regardless of who pays these costs – government or the private sector – unless we can find a way to improve the health of our citizens.” The *WSJ* then touted the Safeway program as “a well-designed health-care reform, utilizing market-based solutions” that can “ultimately reduce our nation’s health-care bill by 40%.”

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34 *WSJ*, Opinion “How Safeway Is Cutting Health-Care Costs” by Steven A. Burd (June 12, 2009). What Safeway did under its voluntary “Healthy Measures Program” was to test its nonunion employees on tobacco usage, healthy weight, blood pressure and cholesterol levels and then set their share of annual health care premiums based on the results of such tests. If an employee passed all four tests, their premiums were reduced $780 for individuals and $1,560 for families. [http://online.wsj.com/article/SB124476804026308603.html](http://online.wsj.com/article/SB124476804026308603.html). This article had a huge impact on the health care reform debate on Capital Hill. President Obama favorably cited the Safeway program when it had only been in place for six months. But see, *The Seattle Times*, “Misleading claims about Safeway wellness incentives” by David S. Hilzenrath (Jan. 23, 2010) where, after examining the underlying data, the *Times* takes issue with the savings claims cited by the *WSJ*.
It is important to understand that the ROI and health-related benefits of any wellness program will not be apparent overnight. Programs that stress compliance with medications, for example, may initially drive up prescription drug costs. The resulting improvements in the participant’s health and concomitant savings in medical costs will lag behind the increase in prescription drug costs. In determining whether any wellness program has been successful and produces an acceptable ROI, it is important to set realistic goals with quantifiable measurements over sufficient periods of time to properly measure such indicators. Even where the workforce’s health risks are reduced as little as 1.7%, studies have found that the employer will break even on its investment in wellness in ten years.35

4. liability for injuries of participants in the program

Sponsors of wellness programs do not want to be sued if an individual is injured in the course of participating in such programs. There are practical steps that can be taken to help alleviate some of this concern.

i. waivers

Whether the voluntary wellness program is conducted on the employer’s premises or off-site, it is always advisable to have the participants sign a carefully crafted waiver in order to insulate the sponsor of the program from liability for injuries that occur as a result of participating in such program. Consultants who are retained to conduct wellness programs should have separate waivers. In some states like California, such waiver will never shield the sponsor from liability for injuries caused by gross negligence.

Even where workers are injured while participating in wellness programs and such injuries are found to be compensable under a state’s workers’ compensation law, the overall cost of such award to the employer in increased insurance rates should not be a deterrent to establishing a wellness program.

ii. workers’ compensation claims

One court in New York recently ruled that an employee who injured himself while participating in an employer-sponsored exercise class was entitled to workers’ compensation benefits.36 In this case, the court agreed with the Workers’ Compensation Law Judge who determined that the claimant’s spinal cord injury arose out of and in the course of his employment. Specifically, the court held,

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35 Supra. at 20.
[A] claimant cannot recover workers’ compensation benefits for an injury arising out of his or her ‘voluntary participation in an off-duty athletic activity not constituting part of the employee’s work related duties unless the employer (a) requires the employee to participate in such activity, (b) compensates the employee for participating in such activity or (c) otherwise sponsors the activity.

... Assuming that claimant was off duty when he took the circuit class, he was neither compensated for nor required to participate in it. As such, he was obliged to show that the employer sponsored the activity, which required ‘an affirmative act or overt encouragement by the employer to participate’.

... Claimant was encouraged by the employer to have a gym membership. Indeed, the employer offers reimbursement to its employees for half of their G.E. Fitness Center membership fees, although claimant elected not to seek that reimbursement. Moreover, claimant’s position required him to develop contacts with current and prospective clients, and both he and the employer’s president stated that participating in the circuit class furthered that function. Given those facts, we conclude that the Board’s determination is supported by substantial evidence.

This decision reflects the exception to the general rule in New York and other states that claimants cannot recover for injuries arising out of their voluntary participation in an off-duty athletic activity not constituting part of the employee’s work-related duties. However, where, as in the Torre case, an employer requires an employee to participate in such activities and compensates them for so doing, or, as in this case, otherwise “sponsors” the activity by overtly encouraging the employee to participate in such activity, liability will likely lie under some states’ workers’ compensation laws.

This case also illustrates how important it is make wellness programs totally voluntary. However, under this limited analysis, it leaves open the issue of whether an employer that pays in whole or part for a totally voluntary wellness program, without other overt encouragement, can become a “sponsor” of such whereby such injuries potentially become compensable under that state’s workers’ compensation law. Obviously, such determinations would have to be based on the application of a particular state worker compensation law to facts of each case.

In the final analysis, in determining whether or not to offer a wellness program, an employer should weigh how often such injuries would likely occur and then be found to be compensable under workers’ compensation insurance (thereby potentially increasing the employer’s compensation insurance costs) with how much it would save by decreasing its health care costs for all the participants in the
wellness program. Clearly, under this limited type of cost analysis, it appears highly likely that the scales would tip in favor of sponsoring such voluntary wellness programs.

B. Legal Issues

There are host of thorny legal issues one can encounter in establishing a wellness program. Some have likened the complexities of overlapping laws, such as the ADA, HIPAA, GINA, FMLA and state anti-discrimination and privacy laws that regulate various aspects of wellness programs as the new “Bermuda Triangle”\(^{37}\). The uncertainty created by the different analyses required by these laws requires caution in establishing such programs. However, these sometimes murky legal obstacles can be successfully navigated if one proceeds with caution.

Before examining the specific requirements of the various laws that regulate wellness programs, it is important to examine the general privacy issues that present a major concern for both sponsors and participants in wellness programs.

1. Privacy concerns (the horse is out of the barn but...)

Privacy concerns have affected every aspect of our daily lives\(^{38}\). Hardly a week goes by that we do not read about how our personal information that has been stored in one company’s or another’s computerized data base\(^{39}\) has been stolen by sophisticated hackers. Indeed, Google, the world’s largest search engine, has recently turned to the National Security Agency for technical assistance after its cyber security defenses were breached last year by a Chinese-based hacking effort.\(^{40}\)

This unease about our privacy is heightened as more and more electronically stored\(^{41}\) health-related information falls into the hands of criminals, many of whom operate outside


\(^{38}\) In a somewhat ironic reflection of such concern, even “Facebook” has a privacy policy. http://www.facebook.com/policy.php

\(^{39}\) Those who use Microsoft search engines, including its new search engine Bing, to conduct health-related searches may take some comfort in learning the Microsoft recently announced that it will delete user search data, including IP addresses after six months, in order to comply with European privacy laws. http://epic.org/2010/01microsoft-to-delete-search-dat.html

\(^{40}\) ABAJournal.com (Feb. 4, 2010). http://www.abajournal.com/mobile/google_seeks_help_from_spy_agency_onhack_attacks

\(^{41}\) In January 2005 the Bush Administration called for the creation of a national network of electronic health records (“EHR”) within 10 years. President Obama, as well as all the other candidates, embraced EHR as an important measure to contain rising health care costs. In signing the American Recovery and Reinvestment Act of 2009, Public Law No: 111-5 (the stimulus law) President Obama has allocated $19 billion to implement electronic health records by the year 2014.
the U.S. These criminals, who are often part of highly organized criminal enterprises, access such data by hacking into entire systems or by conveniently accessing it from a “misplaced” and unprotected laptop where such unencrypted data has been stored.\textsuperscript{42} This information is then sold to the highest bidder or, as we recently witnessed in the case involving Express Scripts, Inc, a prescription benefit manager, the criminal(s) seek to blackmail the entity from which such data has been stolen by threatening to release tens of thousands of individual health care records.\textsuperscript{43}

There are scores of federal and state laws that protect various aspects of our privacy.\textsuperscript{44} Protection of our medical records is primarily governed by the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), which sets the basic protections that must be provided. However, HIPAA only applies to medical records maintained by health care providers, health plans and health clearinghouses and only where such records are maintained in electronic form. States, of course, may enact stricter provisions.

Our payments to health care providers for treatments, payments of insurance premiums, filing of OSHA complaints, and applications for gym memberships, health or disability insurance and FLMA applications, just to name a few, often contain personal health information. These records are maintained in many other places that are not governed by HIPAA. The privacy of these records, if protected at all, is governed by a complex and often confusing panoply of federal and state laws that afford varying levels of protection.

Unfortunately, when there is an unauthorized disclosure of health-related information, it is often impossible to pin point where the breach occurred and whether we have in fact unwittingly authorized such disclosure.\textsuperscript{45} With so many portals for access to our health-related records, in many respects, the horse is indeed out of the barn. Indeed, when an unauthorized release of protected health information occurs, some employees assume, without proof, that their employer or union-sponsored health plans are to blame. In such cases, if employers or unions that have health plans or that offer wellness programs can prove they have followed the security mandates of HIPAA and ARRA and any applicable state laws in protecting the health-related information gathered pursuant to such plans and wellness programs, they should have a viable defense to actions by those who file claims

\textsuperscript{42}According to the 2010 Identity Fraud Survey Report issued by Javelin Strategy and Research, 11.1 million adults were victims of identity fraud in 2009, representing a 12% increase over the preceding year and losses of approximately $54 billion. See Chamberlin, G., The Daily Transcript – San Diego Source (Feb. 13. 2010). \url{http://www.sddt.com/Search/article.cfm?SourceCode=20100212tbc}. Note that in 2007 medical identity fraud, potentially the most deadly type of fraud (because your medical records, e.g. your blood type and medical history can be changed), accounted for 3% of all identity fraud. Coalition Against Insurance Fraud, citing Federal Trade Commission \url{http://www.insurancefraud.org/medicalidentitytheft.htm}.

\textsuperscript{43}See Express Scripts, Inc. press release, \url{http://phx.corporate-ir.net/phoenix.zhtml?c=69641&p=irol-newsArticle&ID=1223389}. See also Amburgy v. Express Scripts, Inc., 2009 U.S. Dist. Lexis 109100 (USDC, Eastern District Missouri), 11/23/2009 where plaintiff’s claim for damages as a result of said blackmail was dismissed for lack of standing and failure to state a claim.


\textsuperscript{45}Privacy Rights Clearinghouse: “Fact Sheet 8: Medical Records Privacy” (revised 2009). \url{http://www.privacyrights.org/fs/fs8-med.htm}.
against them for the unauthorized release of their private health-related information. Whether such a defense succeeds largely will depend upon the diligence the employer or union has taken in complying with such security mandates, which includes properly documenting compliance with applicable laws.

One of the more troublesome concerns for both employers and employees involves the protection of health-related information that workers are often asked to give when participating in a wellness program. For example, as many wellness program go beyond the archetype health fairs, blood pressure screenings and handing out of health-related brochures. Many now are utilizing health risk assessment (“HRA”) forms that ask workers to divulge sensitive health information, including family health histories. Even where such information is not gathered via an HRA, critical individual health-related data is often gathered from those who merely participate in weight loss, smoking cessation or other wellness programs. Many who participate in such programs often provide their personal health information on computerized forms that may stored without appropriate privacy safeguards in place.

Workers also fear that their health-related information will be used by the employer in making hiring, assignment, promotion and even termination decisions. In addition, workers fear that such information will be shared with insurers or group health plans rendering them ineligible for coverage, limiting their coverage or that it will be cause for charging them higher premiums, co-pays or deductibles.

The discussion below focuses on the various laws that regulate the creation and maintenance of wellness programs. Some of these laws overlap or leave unanswered questions or create an often confusing set of regulations that are difficult to apply. Diving into these waters often is akin to swimming with rip tides.

2. HIPAA/ARRA

A. Nondiscrimination

The nondiscrimination provisions of the HIPAA, prohibit discrimination against a health plan participant or beneficiary based on such person’s health factors. Basically, HIPAA provides that no person can be denied group health insurance or charged a higher premium than other similarly situated persons because of his/her health status, genetic history, evidence of insurability, disability or claims experience. Therefore, a health plan’s rules cannot discriminate on the basis of an individual’s health factors. However, a plan may design its benefits to exclude or limit coverage for certain specific diseases or

46 According to a presentation made by Marianne Steger, MSLS, CEBS, Director of Health Care and Public Policy for AFSCME’s Ohio Council 8 at the 2009 IFEB Annual Employee Benefits Conference, many sponsors of wellness programs turn to outside specialized companies to manage their wellness programs. Such companies maintain employees’ health-related records off-site and the employer/union only have access to aggregated data, thereby ensuring that such information will not influence any individual employment-related decisions.

47 Pub.L. 104-191.
treatments, provided the effect of such limitation or exclusion does not single out identifiable participants. These nondiscrimination rules apply to groups of similarly situated individuals, e.g. full-time versus part-time employees, unionized employees, active versus retired employees, etc. In addition, health reimbursement arrangements are permitted provided they are not based on an individual’s claims experience but rather are a set amount available to all similarly situated individuals.48

On December 13, 2006 the Departments of Labor (“DOL”), Treasury and Health and Human Services (“HHS”) (collectively “Departments”) issued final rules that clarified the applicability of the non-discrimination provisions to wellness programs that offer financial rewards. These rules became effective for plan years starting on or after July 1, 2007.

Generally, HIPAA’s nondiscrimination provisions prohibit a plan or insurer from charging similarly situated individuals different premiums or contributions based on a health factor. However, as indicated in the final rules, “such nondiscrimination provisions do not prohibit a plan or insurer 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. Therefore, there is an exception to the general rule prohibiting discrimination based on a health factor if the reward, such as a premium discount or waiver of a cost-sharing requirement, is based on participation in a program of health promotion or disease prevention.”49 Thus, it is now clear that wellness programs subject to HIPAA’s nondiscrimination rules are those that condition receipt of an award on satisfying a standard that is related to a health factor or for participating in the program. However, the analysis does not stop there.

Under HIPAA’s final rules, such plans are required to satisfy five rules where rewards are offered: (1) the amount of the “reward” may not exceed 20% of the cost of the employee’s coverage or 20% of the cost of family coverage if dependants can participate in the program, (2) the program must be “reasonably designed” (i.e. is not burdensome or created to be a subterfuge for discriminating based on a health factor and have a reasonable chance to improve health or prevent disease) to promote health or prevent disease, (3) the program must give eligible persons an opportunity to qualify for the reward at least one a year, (4) the reward must be available to all similarly situated individuals unless such program provides for a reasonable alternative standard or waiver for individuals who have difficulty meeting the standard due to a medical condition preventing them from meeting the standard (It is permissible to ask for verification of said medical limitation.), and (5) all plan materials that describe the program must disclose the existence of a reasonable alternative standard or how to obtain a waiver.

Conversely, plans that do not condition awards on satisfying a standard related to a health factor will not be subject to HIPAA’s nondiscrimination provisions provided participation in the program is made available to all similarly situated individuals. Examples on such

plans include but are not limited to those that reimburse all employees who join a gym or that offer a reward to all who take a certain test (like cholesterol screening) or who participate in a smoking cessation program without regard to whether they achieve a particular result.

DOL staff have opined that a wellness program is only subject to the HIPAA nondiscrimination rules if it is part of an ERISA health plan as defined in ERISA section 3(1). However, if the program is an employment policy separate from the group health plan, such program will not be subject to ERISA plan rules but may be subject to the ADA and GINA and certain other federal and state laws. Although the Departments were asked to offer guidance in the final rules on what affect HIPAA’s nondiscrimination provisions that permitted some practices that other federal and state laws, including ADA, FMLA, Title VII appear to prohibit, they declined to do so. Instead plans were cautioned to contact their legal counsel to determine compliance with such other laws. As a result, the Departments have ensured full employment for plan and insurance lawyers for the foreseeable future.

Generally, Congress intended to preempt state insurance laws only to the extent that those requirements prevented the application of the basic protections set forth in HIPAA. In articulating this standard the Departments recognized that state insurance laws that were more stringent than federal requirements were unlikely to ‘prevent the application’ of HIPAA’s nondiscrimination provisions, hence States have significant latitude to impose more restrictive provisions. 50

B. Privacy & Security

HIPAA also gave birth to a range of health care reforms51, including privacy and security provisions. However, HIPPA’s original privacy rules were adopted by regulation implemented through the Department of Health and Human Services (“HHS”), particularly HHS’ Centers for Medicare and Medicaid Services (CMS). 52 These rules were issued in 2000 and later amended in 2002. They became effective in April 2003. HIPAA’s privacy rules are far more detailed than the security rules.

In passing HIPAA, Congress indicated that state laws that are contrary to HIPAA can stand provided such laws come within one of the four exceptions to HIPAA preemption.53 In the area of privacy, a more stringent state law will not be preempted by HIPAA if it specifically “relates to the privacy of individually identifiable health information”54

51 Many of the later reforms that followed, including the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, Michelle’s Law and the Children’s Health Insurance Program Reauthorization Act built on HIPAA’s framework to create new individual rights relating to eligibility and enrollment for health benefits.
53 See, HIPAA, §1178, et seq.
HIPAA’s privacy rule applies to health care providers, clearinghouses and health plans, which include employer-sponsored group health plans, but not the employer. This privacy rule did not cover business associates of covered entities. However, the covered entity was required to provide in the business associate agreement that business associate must make protected health information available if and when needed by the covered entity to provide an individual with access to his/her health information.

These HIPAA privacy rules were subsequently beefed up through the passage of the American Recovery and Reinvestment Act\(^55\) (“ARRA”), which President Obama signed into law and which became effective for many covered entities on February 17, 2009. ARRA’s provisions now extend privacy rules to covered entities and business associates\(^56\), whether or not they utilize or have access to electronic health records.

In light of the substantial federal funding that was to be allocated to support the expansion of electronic medical records in order to improve patient safety, to promote quality care and to make the health care system more efficient, there was particular concern among many average citizens over the protection of such electronic health records. An expression of this concern appears in a letter the ACLU wrote to Congress urging them to pass the additional IT provisions of ARRA, known as the Health Information Technology for Economic and Clinical Health Act (“HITECH”). “Without the privacy provisions proposed in the HITECH Act, Americans will fear justifiably that their most private, personally identifiable information concerning their medical histories and conditions will be available to prying eyes.”\(^57\)

The additional ARRA HITECH protections may help to quell some of the fears of wellness program participants that their personal and/or health-related information will end up in the wrong hands. The HITECH provisions protect a much broader list of “identifiers”, including but not limited to: electronic mail addresses, medical record numbers, health plan beneficiary numbers, biometric identifiers, photographs, telephone numbers, dates of birth, ZIP codes, the date a person was admitted or discharged from the hospital and the name of the person’s employer, etc.\(^58\) thereby greatly extending the protections provided under most state privacy laws.

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\(^{55}\) Pub. L. 111-5.

\(^{56}\) Lawyers for covered entities, particularly self-insured plan sponsors, should make certain that their clients’ business associate agreements were amended to include the added protections and breach notification requirements of the HITECH Act and that such signed BA agreements were retuned, where applicable, by February 17, 2010. It should be noted that although the HITECH Act still does not require group health plans to monitor their business associates, plan sponsors still have an obligation under ERISA to do so.


\(^{58}\) 45 C.F.R. §164.514(b)(2)(i).
C. State laws

There are innumerable state laws that protect various aspects of an individual's privacy. In many instances, when it comes to protecting health-related records, these state laws fill important gaps by covering entities which are not subject to the HIPAA Privacy Rule but which maintain our health records for various permitted reasons. Such HIPAA-exempt records can include health-related information we provide to financial institutions that may share our records with affiliated companies, credit card and checking transactions that include information on our purchases of health care, our insurance applications and claim forms, our education records and those of our children, certain employment records that can include OSHA reports and FMLA-related medical information. Our health-related information can also be gathered through employee health programs offered by employers through outside contractors.

The state laws that cover the various aspects of these types of health records are too numerous to list in this article. However, the Georgetown University Center on Medical Records and Privacy has compiled an excellent list of state laws that protect the privacy of our medical records. Typically these state laws address how one can obtain copies of one’s health care records; how errors in such records can be corrected; by whom and how long such records must be maintained. Importantly, such state laws can exceed the protections provided by HIPAA because they often regulate entities not covered by HIPAA.

3. ADA & ADAAA

The Americans with Disabilities Act of 1990 (“ADA”), prohibits discrimination in employment against qualified individuals who are disabled. The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities. It also protects individuals who have a record of, or, who are regarded as having an impairment. This law requires employers to make “reasonable accommodations” for known physical and mental limitations of qualified individuals unless doing so would result in an “undue hardship” on the employer or would pose a direct threat to the health or safety of others.

Under the ADA, employers are prohibited from asking job applicants medical questions (unless it relates to their ability to perform an essential function(s) of the job) or require that they pass a pre-offer medical examination. However, once the position is offered, employers are permitted to make such offer contingent on passing a medical examination provided such exam is required of all employees holding similar jobs and is job related and


60 See Georgetown University Center on Medical Records Rights and Privacy for information on medical privacy rights in all the states http://hpi.georgetown.edu/privacy/records.html.


consistent with the employer’s business needs. The employer is required to keep all medical information confidential.

In the context of this discussion, the ADA requires employers to provide disabled employees with equal access to employer-provided benefit programs, including incentives, and it prohibits employers from denying such benefits or providing different benefit terms and conditions based upon the employee’s disability. This prohibition does not bar employers from offering a bona fide benefit plan that pays benefits but excludes or limits coverage for certain treatments, for example, weight-loss and obesity-related treatments, provided such limitations do not specifically target disabled individuals and provided the benefit plan has been accurately communicated to eligible employees.63

On September 25, 2008, President Bush signed the ADA Amendments Act of 2008 (“ADAAA”)64, which amended the Americans with Disabilities Act of 1990. This amendment became effective on January 1, 2009. The purpose of the ADAAA was to reinstate a broad scope of protection thereby rejecting several Supreme Court decisions and portions of the EEOC’s ADA regulations. The ADAAA expanded considerably the definition of “major life activities” and added a new category of major life activity: “major bodily functions”, which included, but were not limited, to functions of the immune system, cell growth, digestive, bladder and bowel functions, neurological and brain functions, respiratory and circulatory functions, endocrine functions and reproductive functions. The clear intent was to favor broad coverage and to dramatically expand the scope of coverage under the “regarded as” prong of the definition of “disability” making reasonable accommodations more likely for many employees previously excluded from the ADA’s protections.65

A. the “voluntary” exception

Importantly, neither the ADA nor the ADAAA prohibit the implementation of wellness programs aimed at promoting good health and preventing disease. Indeed, the ADA allows employers to conduct voluntary medical examinations and activities, including taking voluntary medical histories which are part of an employee health program without having to show that they are job-related and consistent with business necessity, as long as employees are not penalized for non-participation66 and any medical records acquired as part of the wellness program are kept confidential and segregated in a medical file that is separate from personnel records.67 Often such programs include blood pressure screening,

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64 Pub.L. 110-325.
67 EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans With Disabilities Act, citing H.R. Rep. No. 101-485, pt.2 at 75 (1990) (“As long as the programs are voluntary and the medical records are maintained in a confidential manner and not used for the purpose of
cholesterol testing, glaucoma testing, and cancer detection screening. Employees may not be asked disability-related questions pursuant to such voluntary programs.68

B. ADA issues involving use of HRAs and incentives

Some opine that the EEOC ADA Informal Discussion Letter and the GINA Interim Final Regulations may restrict the implementation of wellness programs and the incentives that are often utilized by employer-sponsored group health plans.69 Others have urged the EEOC to provide additional guidance on what constitutes penalties, permissible incentives and voluntary programs under the ADA.70 These issues are discussed below.

The EEOC issued an opinion letter on March 6, 2009 regarding the use of health risk assessment forms ("HRA"). HRAs often elicit very detailed health information from participants, including genetic information. In its opinion letter, which is advisory in nature, the EEOC reaffirmed that disability-related and medical examinations are permitted as part of any voluntary wellness program provided there are no adverse consequences to employees who elect not to participate in such programs.71 In the case which prompted the EEOC to issue the above-referenced letter, the employer used an employee’s refusal not to participate in the HRA as grounds to deny him the opportunity to obtain health coverage through the employer’s plan, an adverse consequence, according to the EEOC that violated the ADA. The EEOC stated: “...the program would not be voluntary, because individuals who do not participate in the assessment are denied a benefit (i.e., penalized for non-participation) as compared to employees who participate in the assessment.”72

In June, 2009 the EEOC was asked if the ADA permitted an employer to require all of its employees to complete a HRA in order to receive monies from an employer-funded health reimbursement arrangement. On August 10, 2009, EEOC issued an Informal Discussion Letter indicating that where an employer penalizes employees who refuse to fill out a HRA that was part of a wellness program by making him ineligible to receive reimbursement for health expenses, such employer created an involuntary program thereby violating the

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68 Supra. If a program simply promotes a healthier life style but does not ask any disability-related questions or require medical examinations (e.g., a smoking cessation program that is available to anyone who smokes and only asks participants to disclose how much they smoke), it is not subject to the ADA’s requirements concerning disability-related inquiries and medical examinations.


70 Molenda, C., Smith, S., et al., Group Health Plans: Federal Mandates Other Than COBRA & HIPAA, Thompson Reuters/EBIA Manuals (4th Qtr. 2009) 790. This manual provides a detailed list of the enforcement guidance and informal discussion letters offered by EEOC & HHS on the application of the ADA’s provisions to wellness programs.

71 Supra. EEOC’s Mar. 6, 2009 letter.

72 Id.
ADA’s prohibition against making disability-related inquiries. The EEOC went on to list the questions on the HRA that would be permitted because they were “not likely to elicit information about a disability, and therefore,” would not be “subject to the ADA’s restrictions.” Based on EEOC’s innocuous list of permitted questions, it is clear we may ask how many vegetables employees eat but we may not ask if they experience flatulence after having done so or if they have a family history of flatulence.

4. GINA

The Genetic Information Nondiscrimination Act (“GINA”) was enacted on May 21, 2008. GINA has two parts: Title I and Title II. Because of the difference in what these two Titles regulate, they have different definitions of what constitutes a “genetic test.”

Title I

Title I applies to group health plans sponsored by private employers, unions, state and local government employers and other entities. The interim final rules for Title I, which were issued by DOL, HHS and Treasury (“the Departments”), became effective for most health plans on December 7, 2009. Title I amends portions of ERISA, the Public Health Service Act and the Internal Revenue Code and it addresses the use of genetic information in health insurance.

Specifically, Title I prohibits group health plans and issuers from: 1) increasing premiums for the group based on genetic information; 2) requesting or requiring an individual or family member to undergo a genetic test; or, 3) requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes. Similar prohibitions apply to the individual health insurance market.

The Departments interpreted GINA’s ban on collecting or using individuals’ genetic information for “underwriting purposes” to encompass monetary incentives for completing HRAs that ask about family medical history. Eric Ugoretz, President of the ERISA Industry Committee, urged that the implementation of these rules should be delayed “to understand how the regulations will affect workplace wellness programs.” He believed that “if group health plans are prohibited from offering participants incentives to complete confidential HRAs that include family medical histories, these programs will become far less

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74 Supra.


76 29 C.F.R. Part 1635, Section 1635.3(f).


78 The HHS is required by these rules to revise the HIPAA privacy regulations to prohibit the use of genetic information for underwriting purposes. 74 Fed. Reg. 51664 (Oct. 2009).

In inviting comments on eliminating incentives to complete HRAs, the Departments had indicated in their October 2009 Interim Final rules that they did not have sufficient data to determine if incentives for filling out HRAs were eliminated whether HRA response rates would drop and, as a consequence, whether there would be a measurable cost associated with the forgone benefits of identifying disease risks early and preventing their onset.

Title II

Title II prohibits genetic discrimination in the employment context. Currently the only guidance we have on Title II of GINA, are EEOC’s Interim Final Regulations that were published on March 2, 2009. Title II prohibits covered entities from using genetic information in employment, from intentionally acquiring genetic information about applicants and employees and imposes strict confidentiality requirements on any genetic information that is acquired.

Specifically, Title II of GINA makes it unlawful for private, state and local government employers with 15 or more employees to 1) “fail or refuse to hire, or to discharge, any employee, or otherwise to discriminate against any employee with respect to the compensation, terms, conditions of employment of the employee because of genetic information with respect to the employee or; 2) “to limit, segregate, or classify the employees of an employer in any way that would deprive or tend to deprive any employee of employment opportunities or otherwise adversely affect the status of the employee as an employee because of the genetic information with respect to the employee.” Title II adds genetic information to the list of protected categories covered by Title VII of the Civil Rights Act of 1964 and therefore it applies to the same entities that are covered by Title VII.

Genetic information includes the employee’s own genetic information as well as that of his/her family. Under Title II, use of such information is prohibited in regard to all employment decisions, including the provision of fringe benefits. Although many states

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82 EEOC allowed an employer could acquire family genetic information unintentionally by for example a supervisor overhearing conversations among co-workers. This inadvertent acquisition was dubbed by Congress as the “water cooler problem”. In addition, an employers’ acquisition of genetic information in regard to requests for a reasonable accommodation under the ADA or state or local law is generally considered to be inadvertent. Section 1635.8, 29 C.F.R. 9061.
83 The ADA permits employers to require post-offer medical examinations to determine an applicant’s current ability to perform a job. GINA does not prohibit such medical examinations provided such exams do not obtain genetic information, including family medical history. Likewise, an employer that lawfully acquires genetic information from an individual requesting a reasonable accommodation under the ADA would not violate GINA. However, requiring such information in determining an appropriate accommodation would run afoul of GINA. An employer that inadvertently receives such information in regard to an FMLA request, likewise, would not violate GINA. See Section 1635.8, 29 C.F.R. 9061.
had passed their own genetic non-discrimination laws, Congress felt compelled to address such discrimination on a comprehensive basis in the areas of health insurance and employment.85

There are six narrow exceptions to the prohibitions in GINA.86 One of those exceptions permits genetic information to be obtained by covered entities that sponsor wellness programs but only if such information is voluntarily given by the employee and provided that the employee is not penalized if s/he decides not to voluntarily provide such information. Any genetic information that is disclosed must be confidential and maintained in a separate medical file.87 In requiring that such information be provided voluntarily, EEOC specifically indicated that: “GINA permits covered entities to offer health or genetic services”... “as part of a wellness program”. EEOC further noted that “a wellness program seeking medical information must be voluntary, which requirement is set forth in the ADA.”

EEOC indicated that the ADA’s Enforcement Guidance provides that a “wellness program is voluntary ‘as long as an employer neither requires participation nor penalizes employees who do not participate.’” As EEOC had not further addressed how the term “voluntary” should be defined, it invited comments concerning the scope of that term.

EEOC received about 40 comments many of which sought further guidance on what constitutes a voluntary program, particularly ones that offer any financial incentive to provide genetic information.

5. ADEA & OWBPA

The Age Discrimination in Employment Act of 1990 (“ADEA”)88 prohibits employers from discriminating against its workers with respect to compensation, terms, conditions or privileges of employment, because of the worker’s age.

After the Supreme Court’s ruling in Public Employees Retirement System of Ohio v. Betts,89 Congress enacted the Older Worker Benefit Protection Act of 1990 (“OWBPA”),90 to amend the ADEA to prohibit age discrimination in employee benefits. OWBPA rejected Betts by specifically indicating that non-discrimination provisions of the ADEA included those

where genetic privacy laws are pending, please see NCSL’s Genetic Legislation Database. Predictably, Connecticut, where many large insurance companies are headquartered, has not passed any laws protecting genetic privacy. Even fewer states have enacted laws restricting the use of genetic information in life, disability and long-term care insurance. See NCSL “Genetics and Life, Disability and Long-term Care Insurance”.


86 Section 1635.8, 29 C.F.R. Part 1635.
87 Id.
90 Pub. L. No. 101-433, 104 Stat. 978 -Amends the Age Discrimination in Employment Act. Section 11 of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 630) is amended by adding at the end the following new subsection: "(1) The term 'compensation, terms, conditions, or privileges of employment' encompasses all employee benefits, including such benefits provided pursuant to a bona fide employee benefit plan."
provided under a *bona fide* employee benefit plan, including wellness programs. Thus, if an employer provides a wellness program, it must do so without regard to the employee’s age. However, employers may provide a lower level of benefits to older employees than to younger employees if it can meet the “equal benefit/equal cost” rule announced in EEOC’s regulations that were expressly incorporated into ADEA’s provisions.

Hence employers have the choice of providing the same wellness program to all its employees, or, they can offer different programs provided the cost of providing such programs is equal. For example, an employer could offer different exercise classes, or difference portions of an exercise class, that are tailored to the levels of exercise the participants can safely endure provided the cost of doing so is equal.

**Conclusion**

Although we lack legal certainty in some areas about how to guide our clients who wish to establish wellness programs, it is clear that such programs can and should be established. In setting up such programs, many of the red-flagged areas discussed above can be avoided by:

1. Educating prospective participants about the value of joining a wellness program by illustrating through hypotheticals the typical savings that can be achieved in an individual’s health-care costs. (Although improved health is clearly an expected benefit of such programs, most people are more motivated to change when they know such change will save them money.)

2. Making the wellness program voluntary by only permitting prospective participants to opt in to such program at least annually after fully communicating all of the details of the program, including how obtain a waiver, how the participants’ health-related information cannot be used in employment decisions and how their health-related information will be safeguarded.

3. Not collecting any health-related information, including family health histories, in-house. If you wish to utilize a health risk analysis, use a recognized outside organization to administer the HRA and be certain it has appropriate safeguards in place to securely store such personal health-related information off-site. The program sponsor may receive such HRA data but only if it is de-identified and is provided in the aggregate. If it is cost-prohibitive to use an outside vendor to collect and store such information, make certain no health-related information is stored in the employee’s personnel file.

4. Avoiding, if possible, offering incentives or rewards to either participate in the program or to satisfy a standard that is related to a health factor. (Improved health and naturally resulting lower health care costs should be sufficient incentives.) Where incentives/rewards are offered, make certain the value of such are *deminimus* (not over 20% of the cost of the employee’s coverage) and that they are available to all similarly situated individuals unless such program provides for a reasonable alternative standard or waiver for individuals who have a medically documented reason why they cannot meet such standard.
5. Never penalizing an employee for not participating in a wellness program. (An early death is sufficient punishment.)

If any of us wishes to be a part of driving down health care costs and improving the health and well-being of workers, we should help our clients through the tricky legal cross currents that must be navigated in establishing such programs. None of the current legal uncertainties present insurmountable obstacles to so doing. With careful planning, drafting and monitoring, we can all become part of the health-care solution, which this nation so desperately needs.

Do not be afraid of arête. Embrace it. Jump into the water and surf the wellness wave but heed the red warning flags and ride the wave with care. In so doing you will experience the exhilarating and natural highs of being a part of lowering health care costs for everyone, improving the health, life expectancy and productivity of workers thereby improving employers’ competitiveness in today’s market. What could be better? Hang ten; give two high fives91.

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91 “Hanging ten”, according to Wikipedia, is a surfing maneuver that is considered to be one of the most impressive and iconic stunts one can perform on a surfboard. It entails positioning the surfboard in such a way that the back of it is covered by the wave and the surfer is free to walk to the front of the board and hang all ten toes over it while thrusting both hands, “high fives”, in the air in celebration of this feat.

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