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Submitted via Federal eRulemaking Portal

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RE: RIN 3046-AB01
Comments on Proposed Amendments to Regulations and Interpretive Guidance Implementing Title I of the Americans with Disabilities Act (ADA), Regarding Employer Wellness Programs

Dear Chair Yang, Commissioners Barker, Feldblum, Lipnic, and Borrow, Mr. Lopez, and Ms. Wilson:

The American Civil Liberties Union (ACLU) submits these comments in response to the Equal Employment Opportunity Commission's proposed rule regarding the application of the ADA to workplace wellness programs. The ACLU is a nationwide, non-partisan organization of approximately 500,000 members dedicated to the principles of liberty and equality embodied in the Constitution and our nation's civil rights laws. The ACLU's Disability Rights Program envisions a society in which discrimination against people with disabilities no longer exists, and in which people with disabilities are valued, integrated members of the community, and have jobs, homes, education, healthcare, and families.

The Commission has erred in formulating its proposed amendments to its ADA regulations and interpretive guidance regarding employer wellness programs. The Commission's draft misconstrues the word "voluntary" from the Americans with Disability's statutory provisions regarding permissible employee medical examinations and inquiries to encompass employer wellness programs that impose significant penalties on employees – up to *30 percent of premiums, or about $1,800.00 annually*. Further, the draft fails to grant due consideration to additional substantive protections that the Act accords persons with disabilities. These include the right not to be discriminated against in the terms and conditions of employment, the right to reasonable accommodation, and the right to medical privacy at work.

Employer-Provided Wellness Programs and Persons with Disabilities.

Voluntary employer-provided wellness programs can provide positive health benefits to employees with and without disabilities. However, in recent years, employers are increasing implementing punitive programs masquerading as voluntary wellness programs. Employees who cannot or who do not wish to participate in these so-called "voluntary" programs must pay higher amounts in health care premiums.

These financial consequences may be called penalties, incentives, or rewards, but whatever the label the most typical result is that an employee who does not comply with the program pays a higher amount of money toward his or her health care premiums. This is because the large majority of employees – around 85 percent – contribute about 20 to 30 percent of the cost of their health insurance coverage.[1] Indeed, between 2004 and 2014, the total cost of the employee share of premiums rose by 81 percent.[2]

The fines being assessed against employees through existing wellness programs are not insignificant. According to the Kaiser 2014 Employer Health Benefits Survey, one third of employers who used financial "incentives" in 2014 charged their employees more than $500 annually.[3] And the Commission's proposed rule would immunize financial charges many times higher – up to 30 percent of the employee's health insurance premium.

People with disabilities are disproportionately harmed by punitive wellness programs. Workers with disabilities are far more likely to have a targeted "health status factor" such as high blood

1 The Kaiser Family Foundation and Health Research & Educational Trust, *2014 Employer Health Benefits Survey*, at 1-2 & Exh. B.

2 *Id.* at 1 & Exh. A.

3 *Id.* at 197.

pressure,4 high blood glucose,5 smoking,6 and being overweight7 or underweight.8 Many people with disabilities take necessary medications that cause weight gain or weight loss, or that result in other changes to blood and urine panels.9 Often, individuals cannot alter their weight or other status through the prescribed wellness activities because they are ineffective, inaccessible, and/or

4 Centers for Disease Control and Prevention, People with Disabilities and High Blood Pressure (Feb. 9, 2015) ("[A]cross all disability types, a greater percentage of adults with disabilities have high blood pressure than adults without any disability, but it is highest among adults with mobility limitations.").

5 U.S. Equal Employment Opportunity Commission, Questions & Answers about Diabetes in the Workplace and the Americans with Disabilities Act (ADA) ("Diabetes is a group of diseases characterized by high blood glucose or sugar levels that result from defects in the body's ability to produce and/or use insulin.").

6 CDC, People with Disabilities and High Blood Pressure, *supra*, n. 4 ("The percentage of adults who smoke cigarettes is higher among people with disabilities than people without disabilities.").

7 *Id.* ("[P]eople with disabilities have more difficulty in maintaining healthy weight than the general public due to a variety of factors, including accessibility issues ...."); Evette Weil, *et al.*, "Obesity Among Adults With Disabling Conditions," 288:10 JAMA 1265 (Sept. 11, 2002) ("After adjusting for sociodemographic factors, adults with a disability were more likely to be obese[.] ... The highest risk occurred among adults with some or severe lower extremity mobility difficulties."); CDC, Disability and Obesity ("Children and adults with mobility limitations and intellectual or learning disabilities are at greatest risk for obesity."); Keydra L. Phillips, *et al.*, "Prevalence and impact of unhealthy weight in a national sample of US adolescents with autism and other learning and behavioral disabilities," 18:8 Matern. Child Health J. 1964 (Feb. 2014) (finding that adolescents with learning and behavioral developmental disabilities were about 1.5 times more likely to be obese than adolescents without developmental disabilities, and that adolescents with autism were about 2 times more likely to be obese than adolescents without developmental disabilities); Suparna Rajan, Ph.D., *et al.*, "Clinical Assessment and Management of Obesity in Individuals With Spinal Cord Injury: A Review," 31:4 J. Spinal Cord Med. 361 (2008) ("[N]early 66% of individuals with SCI are either overweight or obese[.]").

8 Phillips, *supra*, n. 7 (finding that US adolescents with learning and behavioral developmental disabilities are 60% more likely to be underweight than adolescents without these disabilities, and that adolescents with intellectual disabilities are four times more likely to be underweight); Alexandra Mangili, *et al.*, "Nutrition and HIV Infection: Review of Weight Loss and Wasting in the Era of Highly Active Antiretroviral Therapy from the Nutrition for Healthy Living Cohort," 42:6 Clinical Infectious Diseases 836 (2006) ("Despite major advances in the treatment and survival of patients infected with human immunodeficiency virus (HIV), weight loss and wasting remain common problems.").

9 Tilman Wetterling, "Bodyweight Gain with Atypical Antipsychotic," 24:1 Drug Safety 59 (Nov. 2012) (while atypical antipsychotics have been shown to have superior efficacy compared with typical antipsychotics, the frequency and amount of weight gain is high with olanzapine, clozapine, quetiapine, and possibly also zotepine); Dora Liu, *et al.*, "A practical guide to the monitoring and management of the complications of systemic corticosteroid therapy," 9:30 Allergy, Asthma & Clinical Immunology (2013) (describing complications of corticosteroid therapy including weight gain, hyperglycemia and insulin resistance); J. Domecq, *et al*, "Clinical review: Drugs commonly associated with weight change: a systematic review and meta-analysis," 100:2 J. Clin. Endocrinol. Metab. 363 (Feb. 2015) (meta-analysis finding weight gain with amitriptyline (tricyclic antidepressant), mirtazapine (antidepressant), olanzapine (atypical antipsychotic), quetiapine (same), risperidone (antipsychotic), gabapentin (anticonvulsant and analgesic), tolbutamide (antihyperglycemic drug used for the treatment of diabetes), gliclazide (same), nateglinide (same), pioglitazone, glimepiride (same), glyburide (same), glipizide (same), and sitagliptin (same), and finding weight loss with metformin (drug for treatment of type 2 diabetes), acarbose (same), miglitol (same), pramlintide (injectable used to treat type 1 and type 2 diabetes), liraglutide (same), exenatide (same), zonisamide (anti-seizure drug), topiramate (same), bupropion (antidepressant and used for quitting smoking), and fluoxetine (antidepressant). *See also* Alison Poultin, *et al.*, "Weight loss on stimulant medication: how does it affect body composition and bone metabolism? A prospective longitudinal study," 30 Int. J. Pediatr. Endocrinol. (Dec. -2012) (noting that children treated with stimulant medication for attention deficit hyperactivity disorder (ADHD) often lose weight).

unreasonably difficult.[10] Subjecting these workers to inapposite "lifestyle counseling," or penalizing them for failure to meet health targets or outcomes, is unfair and deeply disrespectful.

Mandatory "weigh-ins" and "healthy eating" counseling are particularly harmful for many people with disabilities. Employees with greater weight due to disability have experienced anguish and humiliation in addition to the threat of financial consequences as a result of punitive wellness programs.[11] Some people with histories of eating disorders have reported devastating relapses as a result of participating in these activities.[12] At the same time, there is little evidence that these controversial programs are effective.[13]

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10 Alfred Lewis, *et al.*, "Employers Should Disband Employee Weight Control Programs," 21:2 Am. J. Manag. Care (Feb. 18, 2015) ("There is no published evidence that large-scale corporate attempts to control employee body weight through financial incentives and penalties have generated savings from long-term weight loss, or a reduction in inpatient admissions associated with obesity or even long-term weight loss itself."). *See also* Traci Mann, *et al.*, "Medicare's search for effective obesity treatments: Diets are not the answer," 62:3 American Psychologist 220 (Apr. 2007) (meta-analysis finding little support for the notion that diets lead to lasting weight loss or health benefits: studies show that one third to two thirds of dieters regain more weight than they lost on their diets, and likely underestimate the extent to which dieting is counterproductive because of several methodological problems); CDC, Disability and Obesity ("People with disabilities can find it more difficult to eat healthy, control their weight, and be physically active. This might be due to: A lack of healthy food choices[, d]ifficulty with chewing or swallowing food, or its taste or texture[, m]edications that can contribute to weight gain, weight loss, and changes in appetite[, p]hysical limitations that can reduce a person's ability to exercise[, p]ain [, a] lack of energy[,a] lack of accessible environments (for example, sidewalks, parks, and exercise equipment) that can enable exercise[, and a] lack of resources (for example, money, transportation, and social support from family, friends, neighbors, and community members)."); *cf.* Weil, *supra*, n. 7 (finding that adults with disabilities were as likely to attempt weight loss as those without disabilities, except for adults with severe lower extremity mobility difficulties, who were less likely, and adults with mental illness, who were more likely).

11 Lewis, "Employers Should Disband," *supra* , n. 10 ("Weight reduction programs may also adversely affect morale. Employees usually resist corporate wellness programs that involve surveys, weigh-ins, and screens. … Popular but ineffective 'biggest loser' contests, as well as pay-per-pound-lost programs, create a direct and negative health impact by humiliating people and encouraging crash dieting."); Al Lewis, Vik Khanna, and Shana Montrose, "Workplace Wellness Produces No Savings," Health Affairs Blog (Nov. 25, 2014) ("In addition to the lack of evidence that weight loss saves money, financial incentives tied to weight loss between two weigh-ins may encourage overeating before the first weigh-in and crash-dieting before the second, both of which are unhealthy. One large health plan offers a weight-loss program that is potentially unhealthier still, encouraging employees to use the specific weight-loss drugs that Dartmouth's Steven Woloshin and Lisa Schwartz have argued in the Journal of the American Medical Association never should have been approved due to the drugs' potential harms.") (citation omitted).

12 Bazelon Center for Mental Health Law, Stories of Jane, *et al.* (2015) (on file with Bazelon and ACLU).

13 Lewis, "Employers Should Disband," *supra*, n. 10; Lewis, "Workplace Wellness Produces No Savings," *supra*, n. 11 ("[Wellness programs] cause overutilization of screening and check-ups in generally healthy working age adult populations, put undue stress on employees, and incentivize unhealthy forms of weight-loss. … [W]ellness programs produce a return-on-investment (ROI) of less than 1-to-1 savings to cost. … [T]here is no clinical evidence to support the conclusion that three pillars of workplace wellness—annual workplace screenings and/or annual checkups for all employees (and sometimes spouses), and incentivized weight loss—are cost-effective.") (noting that Safeway's success story has been discredited); Siyan Baxter, *et al.*, "The Relationship Between Return on Investment and Quality of Study Methodology in Workplace Health Promotion Programs," 28:6 Am. J. Health Promotion 347 (July/Aug. 2014) (finding that randomized control trials of wellness programs exhibited negative return on investment); Kevin G. Volpp, *et al.*, "Redesigning Employee Health Incentives — Lessons from Behavioral Economics," 365:6 N Engl. J. Med. 388 (Aug. 4, 2011) ("Although it may seem obvious that charging higher premiums for smoking (or high body-mass index, cholesterol, or blood pressure) would encourage people to modify their habits to lower their premiums, evidence that differential premiums change health-related behavior is scant. Indeed, we're unaware of any health insurance data that

This disproportionate harm is being experienced by a population – workers with disabilities – that is already struggling. According to the U.S. Census Bureau, median household income for people with disabilities is less than half of household income for people without disabilities ($25,974 compared to $61,103).[14] About 31 percent of working-age Americans with disabilities participate in the workforce, compared with about 76 percent of working-age non-disabled Americans.[15] About 29 percent of working-age Americans with disabilities live below the poverty line, compared to 12 percent of working-age non-disabled Americans.[16]

The Commission's Proposed Construction of Section 12112(d)(4) is Inconsistent with the Language and Purposes of the ADA.

Since its effective date, the ADA has provided employees with disabilities with protections against overly intrusive and punitive medical inquiries at work, including employer wellness programs. Specifically, the ADA grants workers the right to be free from the right to be free from medical inquiries or examinations that are not "job related and consistent with business necessity." 42 U.S.C. § 12112(d)(4)(A). The only statutory exception is for "voluntary medical examinations, including voluntary medical histories, which are part of employee health program available to employees at that work site." 42 U.S.C. section 12112(d)(4)(B).

For 15 years, from 2000 until April 2015, the Commission consistently maintained that "voluntary" medical examinations and inquiries could not impose penalties on employees who declined to participate.[17] Moreover, as recently as November 2010 – months *after* the enactment of 42 U.S.C. § 300gg-4 – the Commission reiterated the same rule in the context of its regulations implementing the Genetic Information Non-discrimination Act (GINA).[18]

The new proposal reverses the Commission's longstanding construction of section 12112(d)(4).

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have convincingly demonstrated such effects.") (noting that Safeway's wellness program was implemented too late to deserve credit for flat costs).

14 U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2012, Current Population Reports (Sept. 2013), at 6, table 1; *see also* Soeren Mattke, "When It Comes To The Value Of Wellness, Ask About Fairness Not Just About Effectiveness," Health Affairs Blog (Mar. 18, 2015) (noting increasing numbers of employers planning to impose health-contingent rewards, and describing disparate impact of such rewards based on low socioeconomic status).

15 U.S. Dep't of Labor, Bureau of Labor Statistics, *Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2013 annual averages* (June 11, 2014).

16 U.S. Census Bureau, Income and Poverty in the United States: 2013 (Sept. 2014), at 13.

17 U.S. Equal Employment Opportunity Commission, EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA) (July 27, 2000) ("A wellness program is 'voluntary' as long as an employer neither requires participation nor penalizes employees who do not participate."); Letter of October 9, 2009 from Stuart J. Ishimaru, Acting Chair, EEOC, and Christine M. Griffin, Acting Vice Chair, to Nancy Ann DeParle, Director, White House Office of Health Reform; *EEOC v. Flambeau, Inc*., No. 3:14-00638 (W.D. Wis. 2014); *EEOC v. Orion Energy Systems, Inc.*, No. 1:14-01019 (E.D. Wis. 2014).

18 29 C.F.R. § 1635.8(b)(2)(i)(A) ("This exception applies only 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[.]") (75 Fed. Reg. 68932, Nov. 9, 2010).

Under the Commission's draft standard, an employee could be fined $1,800.00 annually – or even more depending upon the total annual premium – for not participating in prescribed wellness activities or for not achieving a stated health target.[19] For many workers, such a penalty would more than double the amount that they pay for health insurance. This is not a reasonable construction of the word "voluntary."

The Commission should continue to define "voluntary medical examinations" and "voluntary medical histories" as medical exams and medical inquiries that do not penalize workers who do not volunteer. The proposed change – to define "voluntary" as permitting significant financial penalties in the hundreds or thousands of dollars – is inconsistent with the plain language and purposes of the ADA.

A. *The Commission's Proposed Interpretation is Inconsistent with the Statutory Language.*

"Unless otherwise defined, statutory terms are generally interpreted in accordance with their ordinary meaning." *BP America Production Co. v. Burton*, 549 U.S. 84, 91 (2006). Here, the statute states:

> (4) Examination and inquiry
>
> (A) Prohibited examinations and inquiries
>
> A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.
>
> (B) Acceptable examinations and inquiries
>
> A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site. A covered entity may make inquiries into the ability of an employee to perform job-related functions.

42 U.S.C. § 12112(d)(4)(A), (B). There is no suggestion that the medical inquiries and examinations being posed within employer wellness programs are "job-related and consistent with business necessity," or that they are "inquiries into the ability of an employee to perform job-related functions." Rather, the Commission's proposed rule rests on the proposition that the phrase "voluntary medical examinations, including voluntary medical histories," encompasses medical examinations and medical inquiries that may be only be declined by an employee if she or he absorbs an $1,800.00 annual financial penalty.

This is not an ordinary or reasonable construction of the word "voluntary." *See Chevron U.S.A. v.*

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19 According to the Kaiser survey cited at note 1, above, the average annual premium for single coverage is $6,025; 30 percent of this amount $1807.50.

Natural Res. Def. Council, 467 U.S. 837, 842 (1984); *General Dynamics Land System v. Cline*, 540 U.S. 581, 600 (2004) (no level of deference to EEOC's rulemaking is appropriate when the Commission's interpretation of a statute is "clearly wrong"). Consider:

> Employer: "Would you like to participate in this voluntary medical examination that is unrelated to your job duties?"
> Employee: "No, thank you."
> Employer: "Okay, here's your non-participation bill. It's $1,800.00."

Courts similarly consider a voluntary activity to be one that is not required by the employer, and is thus separate from financial considerations or any impact upon the terms and conditions of employment.[20]

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20 Regarding "voluntary" employee trainings: *Kosakow v. New Rochelle Radiology Assocs., P.C.*, 274 F.3d 706, 722 (2d Cir. 2001) ("If Kosakow is able to prove that she was attending these courses as a requirement of her employer, not because she was required to do so by the state, then the attendance would not be considered 'voluntary,' and thus must be compensated under the FLSA. See 29 C.F.R. § 785.27."); *Haszard v. American Medical Response Northwest, Inc*., 237 F.Supp.2d 1151, 1153 (D. Or. 2001) ("Training is not 'voluntary' if it is 'required' by the employer. 29 C.F.R. § 785.28. A plaintiff seeking to show that he is 'required' by his employer to attend training need not show that the employer has a rule terminating those who do not attend training. Instead, training is 'required' if the employee is 'led to believe' that his or her working conditions or continuance of his or her employment 'would be adversely affected by nonattendance.'); *cf. Misewicz v. City of Memphis, Tenn.*, 864 F.Supp.2d 688 (W.D. Tenn. 2012) (remanding to determine whether paramedic training was a fully disclosed precondition of employment, such that attendance was voluntary). Regarding employees and *qui tam* claims: *United States ex rel. Fine v. Chevron, U.S.A., Inc.*, 72 F.3d 740, 744 (9th Cir. 1995) (finding that government employee, with existing job obligation to report fraud to supervisors, could not serve as "original source" relator because he did not provide information voluntarily, citing and quoting definition of "voluntary" from Webster's Third: "Acting, or done, of one's own free will without valuable consideration; acting or done without any present legal obligation to do the thing done or any such obligation that can accrue from the existing state of affairs."); *United States ex rel. Griffith v. Conn*, No. 11–157–ART, 2015 WL 779047 (E.D. Ky. Feb. 24, 2015), at *9 ("In curbing the reach of the original-source exception to the public-disclosure bar, Congress chose to exclude individuals who did not 'voluntarily provide[ ]' the relevant information to the Government. … Congress chose 'voluntarily' as the limiting factor, a decision the Court cannot second-guess. The most apt definition of that word, as discussed above, is an act done 'without a present legal obligation' or 'without valuable consideration.'"); *U.S. ex rel. Stone v. AmWest Sav. Ass'n*, 999 F.Supp. 852 (N.D. Tex. 1997) ("For the purposes of § 3730(e)(4)(B), 'voluntary' is interpreted as 'uncompensated' or 'unsolicited,' not as 'uncompelled.'") (citing *Fine*, 72 F.3d at 744, and *U.S. ex rel. Barth v. Ridgedale Elec., Inc*., 44 F.3d 699, 704 (8th Cir. 1995)); *U.S. ex rel. Varnado v. Caci Intern. Inc.*, 96 CIV. 7827(RWS), 1997 WL 473549 (S.D. N.Y. 1997), at *8 (where Varnado's job "tasks included an affirmative obligation to report any unfulfilled promise or defect in a contractor's software, including defective title," his reports "cannot be called 'voluntary.' *See Fine*, 72 F.3d at 744 (adopting dictionary definition of 'voluntary': 'Acting, or done, of one's own free will without valuable consideration; acting or done without any present legal obligation to do the thing done or any such obligation that can accrue from the existing state of affairs.') (quoting Webster's Third New International Dictionary, 2564 (1981) (definition 1(g)).") *See also In re Earnest David Fielding, and Linda Kay Fielding*, No.: 13–43212–DML–13, 2015 WL 1676877 (N.D. Tex. Apr. 9, 2015), at *8 (noting that "Webster defines the word 'voluntary' as 'proceeding from the will or from one's own choice or consent; acting or done of one's own free will without valuable consideration or legal obligation,' and that the tax court defines payments pursuant to a levy as involuntary) (citations omitted); *In re Tibbs*, 242 B.R. 511, 516-17 (N.D. Ala. 1999) ("[T]he cases all treat a voluntary retirement account as one to which the debtor could cease making contributions at any time and face no adverse action (other than the loss of the retirement benefit). … An involuntary retirement account is best viewed as an account into which a portion of the Debtor's wages are withheld and paid into as a regular contribution and the debtor cannot chose to cease making contributions without severe repercussions."); *In re Hannan Trucking, Inc*., 17 B.R. 475, 478 (N.D. Tex. 1981) ("Webster defines the word 'voluntary' as 'proceeding from the will or from one's own choice or consent; acting or done of one's own free will without valuable consideration or legal obligation.'").

The Commission's construction further defies the dictionary definition of the word "voluntary." *See* Black's Law Dictionary (9th ed. 2009) ("voluntary" is "not impelled by outside influence" and "[w]ithout valuable consideration."); Merriam Webster Dictionary ("unconstrained by interference" and "without valuable consideration").

For the same reason, the suggestion by the Commission that employers have employees participating in wellness programs "provide prior, written, and knowing confirmation that their participation is voluntary," *see* 80:75 Fed. Reg. at 21664, must be rejected. Requiring employees to confirm in writing that they are participating in a "voluntary" program, when the program actually imposes significant penalties for noncompliance, would simply add insult to injury.

Given the plain statutory language of the ADA, the Commission should reject its own proposal, and continue to define "voluntary" to include only wellness programs without financial penalties.[21]

B. *The Commission's New Definition is Contrary to the ADA's Purposes.*

A statutory interpretation should not undermine an important congressional objective. *Young v. United Parcel Service, Inc.*, __ U.S. __, 135 S.Ct. 1338, 1353 (2015). Here, section 12112(d)(4) was enacted to prevent an employer from imposing harassing and stigmatizing medical inquiries on employees – the very problem that is now occurring for many employees as a result of the increased prevalence of punitive corporate wellness programs. As the Commission explained, this construction is consistent with the core statutory purposes of the Act: "" The Commission should not defer to popular but dangerous corporate trends.

As the Commission has previously recognized,[22] the legislative history of the ADA supports the prohibition on punitive on-the-job medical programs. In enacting section 12112(d)(4), the Senate Committee on Labor and Human Resources stated:

> An inquiry or medical examination that is not job-related serves no legitimate employer purpose, but simply serves to stigmatize the person with a disability. For example, if an employee starts to lose a significant amount of hair, the employer should not be able to require the person to be tested for cancer unless such testing is job-related. … While the employer might argue that it does not intend to penalize the individual, the individual may object merely to being identified, independent of the consequences. As was abundantly clear before the Committee, being identified as disable[d] often carries both blatant and

21 To the extent that "voluntary" is consistent with small rewards for wellness activities, the appropriate percentage cap would reflect a truly nominal amount (e.g. $50.00), or about 1 to 3% of the total cost of employee-only coverage.

22 As the Commission explained in its 2000 guidance document: "Historically, many employers asked applicants and employees to provide information concerning their physical and/or mental condition. This information often was used to exclude and otherwise discriminate against individuals with disabilities – particularly nonvisible disabilities, such as diabetes, epilepsy, heart disease, cancer, and mental illness – despite their ability to perform the job. The ADA's provisions concerning disability-related inquiries and medical examinations reflect Congress's intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employers to ensure that individuals in the workplace can efficiently perform the essential functions of their jobs." EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees, *supra*, n.17.

> subtle stigma. An employer's legitimate needs will be met by allowing the medical inquiries and examinations which are job-related.

Senate Comm. on Labor and Human Resources, S. Rep. No. 116, 101st Cong. 1st Sess., at 39-40 (1989); *accord* House Comm. On Education and Labor, H.R. Rep. No. 485(II), 101s Cong., 2d Sess., at 75 (1990) (stating same). These precise concerns are raised by the programs at issue here.

The House Committee on Education and Labor specifically stated that corporate wellness programs must remain voluntary, without impact upon an employee's eligibility for health insurance or employment conditions:

> A growing number of employers today are offering voluntary wellness programs in the workplace. These programs often include medical screening for high blood pressure, weight control, cancer detections, and the like. As long as the programs are voluntary and the medical records are maintained in a confidential manner and not used for limiting health insurance eligibility or of preventing occupational advancement, these activities would fall within the purview of accepted activities.

House Comm. On Education and Labor, H.R. Rep. No. 485(II), 101st Cong., 2d Sess., at 74-75 (1990). The House Committee on the Judiciary similarly noted that "[t]his section does not preclude employers from continuing to offer these [wellness] programs on a voluntary basis. Employers may not require, however, medical examinations which are not job-related and consistent with business necessity." House Comm. on the Judiciary, H.R. Rep. No. 485(III), 101st Cong., 2d Sess., at 44 (1990).

While the Congress did not consider the question of significant financial penalties for non-participation or non-compliance – such mechanisms did not then exist – the underlying stated concern provides relevant guidance. Just as Congress cautioned that such voluntary programs cannot be required, and must not function to impair access to health insurance or working conditions, so too should the Commission construe the provision to prevent significant financial penalties which cause similar harms.

C. *The Commission's New Definition of "Voluntary" Is Not Supported by the Affordable Care Act or Its Implementing Regulations.*

The Commission states that its new definition is appropriate as it must interpret the ADA "in light of" the wellness program provisions and the implementing regulations of the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA). But the ADA does not conflict with the health insurance law. Nothing in the ACA suggests that employers *must* penalize workers who do not comply with wellness programs contained in group health plans.

Importantly, Title I of the ADA and the 42 U.S.C. § 300gg-4 contain different statutory language and serve different statutory purposes. The ACA provision describes nondiscriminatory access to insurance coverage, while the ADA sets the standards for nondiscriminatory working conditions for persons with disabilities. The ACA does not purport to cover the territory regulated by the ADA, and thus compliance with the terms of 42 U.S.C. § 300gg-4 does not indicate compliance with the

ADA. *See K.M. ex rel. Bright v. Tustin Unified School Dist.*, 725 F.3d 1088, 1100-01 (9th Cir. 2013) (discussing differences between ADA and IDEA, and concluding that the success or failure of a student's claim under the IDEA does not determine the outcome of her claim under the ADA).

Consistently, the governing ACA regulation states that "Compliance with this section is not determinative of compliance with any other provision of the PHS Act (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act." 45 C.F.R. § 146.121(h). And the introductory materials to the 2013 implementing regulations repeatedly make the same point.[23]

Reading the ADA's statutory language "in light of" the wellness program provisions at issue, the Commission should not issue final regulations that effectively delete portions of the ADA. Rather, the Commission should explain that wellness programs with financial inducements are permissible, so long as the employee may opt out of any ***medical*** inquiries and examinations without financial penalty. This is consistent with the analogous Commission regulation construing the GINA following the enactment of 42 U.S.C. § 300gg-4. *See* 29 C.F.R. § 1635.8(b)(2)(ii) (covered entity may offer financial inducements, provided that the covered entity makes clear "that the inducement will be made available whether or not the participant answers questions regarding genetic information").

Moreover, the Commission's proposed rule goes beyond the scope of the ACA by permitting penalties for *any* employer wellness programs – whether or not they are part of a group health plan and thus regulated by 42 U.S.C. § 300gg-4.[24] The Commission should exclude from the scope of its rule any wellness program not covered by the ACA.

Further, whatever the merits of purported consistency,[25] the word "voluntary" found in Title I of

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23 See 78:106 Fed. Reg. 33158 (June 3, 2013), at 33165 ("[E]mployers subject to the Americans with Disabilities Act of 1990 (ADA) must comply with any applicable ADA requirements for disclosure and confidentiality of medical information and non-discrimination on the basis of disability."), 33168 ("No Effect on Other Laws … Paragraph (h) of the 2006 regulations clarifies that compliance with the HIPAA nondiscrimination rules which were later amended by the Affordable Care Act), including the wellness program requirements in paragraph (f), is not determinative of compliance with any other provision of ERISA, or any other State or Federal law, including the ADA. This paragraph is unchanged by these final regulations and remains in effect. … As stated in the preamble to the 2006 regulations, the Departments recognize that many other laws may regulate plans and issuers in their provision of benefits to participants and beneficiaries. These laws include, but are not limited to, the ADA … ").

24 Forty-five percent of large employer wellness programs are offered outside of the group health plan. Kaiser Family Foundation, *supra*, n.1, at 202 & Exh. 12.4.

25 The ACA describes five separate levels of permitted financial penalties within various categories of wellness programs –

- unlimited penalties (for "participatory" programs, *see* 42 U.S.C. § 300gg-4(j)(2), 26 C.F.R. § 54.9802-1(f)(1)(ii), (2));
- penalties capped at 30% of the total cost of employee-only coverage (for "health-contingent wellness programs," *see* 42 U.S.C. § 300gg-4(j)(3)(A), 26 C.F.R. § 54.9802-1(f)(1)(iii)-(v), (3)(ii), (4)(ii));
- penalties capped at 30% of a different total, the total cost of the coverage of the employee and his or her dependents (for "health-contingent" programs in which family members may participate, *see id.*);

the ADA cannot stretch so far as to encompass the 30 percent penalty proposed by the Commission.

The Commission's Proposed Regulations and Interpretive Guidance Are Incomplete and Fail to Delineate Relevant Statutory Protections.

In addition to its unsupported construction of the word "voluntary," the Commission's proposal fails to delineate additional relevant statutory protections for individuals with disabilities. The bare cross-reference contained at proposed section 1630.14(d)(7) is inadequate given the stakes.

Should the Commission adopt its proposal regarding section 12112(d)(4) as a final rule, permitting wellness programs with substantial financial penalties, these remaining protections would become particularly critical. For this reason, the Commission should include substantive content on these protections as part of its final regulations and interpretive guidance.

A. *The Commission Should Expressly Endorse and Delineate an Employee's Right to Seek a Reasonable Accommodation, Including a Waiver From a Wellness Program, to Avoid Disability-Based Harms and Penalties.*

A reasonable accommodation under the ADA includes "[m]odifications or adjustments that enable a covered entity's employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities." 29 C.F.R. § 1630.2(o)(1)(iii) (construing 42 U.S.C. § 12112(b)(5)(A)).

It is critical that the Commission expressly confirm that an individual with a disability who is facing unfair, disability-based harms or penalties due to a punitive employer wellness program may seek a reasonable accommodation to avoid this outcome. For workers with disabilities facing the types of harms described herein, *see* pages 1 through 4, *supra*, the only relevant modification may be a waiver from the financial penalties of the program for noncompliance. Because of the variety of disability-based harms that may be threatened, reasonable accommodations including (but not limited to) waivers must be available for both "outcome-based" and "participatory" wellness programs. *See* nn. 11-13, *supra*.

Importantly, the Commission should explain that "reasonable medical documentation" in this context cannot require that an employee disclose the nature or details of the disability that requires waiver. Otherwise, an employee with a disability would be required to submit to a non-job-related

- penalties capped at 50% of the total cost of employee-only coverage (for programs designed to prevent/reduce tobacco use, *see* 42 U.S.C. § 300gg-4(j)(3)(A), 26 C.F.R. § 54.9802-1(f)(5)); and
- penalties capped at 50% of a different total, the total cost of the coverage of the employee and his or her dependents (for tobacco programs in which family members may participate, *see id.*).

The Commission's proposed construction of the word "voluntary" in the ADA does not conform to any or to all of these penalty caps, and instead endorses a new calculation, capping total penalties at 30% of the total cost of employee-only coverage for any form of wellness programs (whether "participatory" or "health-contingent" or a combination) under section 12112(d)(4). The Commission's proposal thus appears to be more an exercise in legislation than in rule-making.

medical intrusion as a condition for avoiding other disability-based harms.[26]

There is no evidence that such waivers would impose any undue hardship on an employer. Employers must already provide a form of reasonable accommodation under the ACA for "outcome-based" wellness programs. *See* 42 U.S.C. § 300gg-4(j)(3)(D)(i). *Cf. Nunes v. Wal-Mart Stores*, 164 F.3d 1243, 1247 (9th Cir. 1999) (weighing against Wal-Mart on its undue hardship defense is the fact that its policy permitted unpaid leaves of up to one year).

B. *The Commission Should Expressly Note that a Corporate Wellness Program May Violate Other Provisions of Section 12112(a) and (b).*

The Commission should further expressly note that activities associated with a corporate wellness program may violate other provisions of sections 12112(a) and (b). For example, certain forms of medical intrusions may constitute discrimination in the terms and conditions of employment. *Cf. Norman-Bloodsaw v. Lawrence Berkeley Laboratory*, 135 F.3d 1260, 1272 (9th Cir. 1999) ("An additional 'term or condition' requiring an unconstitutional invasion of privacy is, without doubt, actionable under Title VII.").

Further, wellness activities that become abusive toward a worker or workers on the basis of disability may constitute disability-based harassment. *Cf. Fox v. General Motors Corp.*, 247 F.3d 169, 179 (4th Cir. 2001); *Flowers v. Southern Regional Physician Services, Inc*., 247 F.3d 229, 236-38 (5th Cir. 2001).

The Commission's Proposed Regulations and Interpretive Guidance on Confidentiality Are Inadequate to Protect the Privacy Rights of Employees.

The Commission's proposed regulation regarding medical privacy for employees subject to wellness programs is inadequate. The ACLU endorses and incorporates herein the comments of the Bazelon Center for Mental Health Law.

The increasing prominence of wellness programs at work sites creates and will create countless opportunities for employers and even co-workers to encounter medical and disability-related information about their employees (as commonly occurred prior to the effective date of the ADA). Disability-related information is likely to become increasingly present in the workplace through activities associated with wellness programs, such as changes to an individual's payroll reflecting wellness penalties, or email and telephone referrals directing an individual to prescribed wellness activities. Such information might be obvious in small workplaces (where even aggregated

26 The certification from a medical professional suggested by the Commission in its introductory remarks is, for the most part, a good model for such documentation. 80:75 Fed. Reg. 21664 (asking "[w]hether, to be 'voluntary' under the ADA, entities that offer incentives to encourage employees to disclose medical information must also offer similar incentives to persons who choose not to disclose such information but who instead provide certification from a medical professional stating that the employee is under the care of a physician and that any medical risks identified by that physician are under active treatment.") However, the phrase "active treatment" contained in the Commission's suggestion may not be accurate for all individuals. For example, for some individuals, the appropriate course of action is not to provide "active treatment,' but rather to simply monitor the person's condition on a regular basis. The Commission should replace this language with a more general phrase, such as, "and that any medical risks identified by that physician are being addressed."

information can be matched with individual employees), or might be accessible to managers in "self-administered" programs. For these reasons, the Commission should require the steps set forth in its Appendix under the heading *Section 1630.14(d)(4)-(6): Confidentiality*, currently described as best practices.

Further, as currently written, proposed section 1630.14(d)(6) appears to regulate the health care plan or other administrator of the wellness program, rather than the employer itself. The language should be rewritten to state affirmatively that covered entities including employers shall not *collect or receive* individually identifiable "information … regarding the medical information or history of any individual."

Conclusion.

The proposed regulation would harm employees with disabilities and should be rejected. The proposed financial penalty levels cannot be reconciled with the language or purposes of the ADA. A program that can only be declined at a price tag of nearly $2,000.00 each year is not "voluntary."

Should the Commission retain its proposed rule, it should exclude wellness programs that are offered outside of the group health plan, as these were not considered by Congress in enacting the ACA.

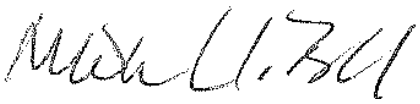
Should the Commission retain its proposed rule, it should delineate the right of employees with disabilities to seek reasonable accommodation waivers to wellness programs (including both "outcome-based" and "participatory" programs). Any reasonable medical documentation associated with such a waiver must not require specific disclosures of disability information.

The Commission should further note that wellness activities may cause disability-based discrimination in the terms and conditions of employment, including disability-based harassment.

Finally, the Commission should bolster its confidentiality rules for these workplace programs.

For more information, please contact ACLU legislative counsel Jennifer Bellamy (202/715-0828; jbellamy@aclu.org).

Sincerely,



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