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How Assuming Autonomy May Undermine Wellness Programs

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How Assuming Autonomy May Undermine Wellness Programs

Jessica L. Roberts,[†] Leah R. Fowler^{††}

Abstract

In recent years, corporate wellness programs have become a routine aspect of the employer-provided health-insurance system. While they vary tremendously in their requirements and incentives, what these programs share is the common goal of modifying employee behavior to improve health and, as a result, to lower costs. However, the effectiveness of wellness programs has been called into question. This Article offers one possible reason for these shortfalls by revealing an assumption underlying wellness programs: encouraging people to make healthier decisions requires that they have access to meaningful choices. Put simply, wellness programs assume personal autonomy. Yet the growing literature on the social determinants of health has revealed that, due to socioeconomic factors and other structural barriers, the ability to make healthy decisions is not equally available to all Americans. We are not equally autonomous. Recognizing this reality can empower employers and health insurers to offer wellness programs that do not assume autonomy but instead facilitate it. The Article concludes with examples of autonomy-enhancing policies for promoting health.

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Contents

Introduction	102
I. Wellness Programs & the Affordable Care Act	106
A. <i>ACA's Wellness Program Incentives</i>	106
B. <i>Effectiveness of Wellness Programs</i>	110
II. The Autonomy Assumption in Wellness Programs	113
A. <i>Role of Choice in Wellness Programs</i>	113
B. <i>Social Determinants of Health</i>	116
III. Autonomy-Enhancing Policy Solutions.....	121
Conclusion	122

Introduction

In the United States, most non-elderly citizens get their health insurance from their employer.¹ This system is notoriously pricey for both employers and employees and has become progressively more expensive over the years as healthcare costs have steadily increased.² In 2015, the average annual premiums for employer-sponsored health insurance were \$6251 for single coverage and \$17,545 for family coverage.³ If trends continue as they have, these average premiums will continue to rise. As a result, corporate wellness programs have become a fixture of the employer-provided health-insurance model as a popular attempt to cabin these ever-increasing costs.

In the context of employer-provided benefits, the term “wellness program” encompasses a broad category of health programs designed to reduce insurance costs by taking a preventive approach to employee health through targeted behavioral interventions. Defined generally as “program[s] of health promotion or disease prevention,” wellness programs are organized efforts to encourage employees—and, in some cases, employees’ dependents—to adopt healthier lifestyles and to address behaviors or inherited characteristics that increase risks for developing preventable illnesses.⁴

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1. GARY CLAXTON ET AL., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2015 ANNUAL SURVEY, 1 (2015), *available at* <http://files.kff.org/attachment/report-2015-employer-health-benefits-survey> (stating that in 2015, over half of working aged Americans were covered by employer-sponsored plans, which were either self-insured plans or plans purchased through a health insurance company, which covers approximately 147 million people).
 2. *See* Matthew Rae et al., KAISER FAMILY FOUND., *Recent Trends in Employer-Sponsored Insurance*, 312 J. Am. Med. Assoc. 1849 (Nov. 12, 2014).
 3. CLAXTON ET AL., *supra* note 1 (stating that employers generally required workers to contribute, on average, 18% and 29%, respectively, for the cost of the premium).
 4. 26 C.F.R. § 54.9802-1(f) (2016); *See also* Jennifer S. Bard, *When Public Health and Genetic Privacy Collide: Positive and Normative Theories Explaining How ACA's*

In the years following the Patient Protection and Affordable Care Act (“ACA”), wellness programs proliferated.⁵ In 2013, about half of United States employers with fifty or more employees offered wellness programs to their employees, a group encompassing approximately three quarters of the U.S. workforce.⁶ Moreover, several parts of the ACA that promote workplace-wellness programs have taken effect, creating additional interest.⁷ Beyond the increase in the number of wellness programs, the wellness-program industry has seen unprecedented financial success. In 2014, workplace wellness represented an over six-billion-dollar industry in the United States, and it is projected to grow by 8.4 percent annually to \$12.1 billion between 2015 and 2020.⁸

Despite increased investment in wellness programs and a booming industry supporting their development and administration, enthusiasm for the programs appears, by some metrics, to be waning.⁹ A survey from the Society for Human Resource Management has found that some of these efforts aimed at improving employee health, including health coaching and

Expansion of Corporate Wellness Programs Conflict with GINA’s Privacy Rules, 39 J. L. Med. & Ethics 469, 471 (2011).

5. See KAREN WESSELS ET AL., SOC’Y FOR HUMAN RES. MGMT., *SHRM Survey Findings: 2014 Strategic Benefits – Wellness Initiatives* 9 (Jan. 22, 2015), available at https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/SHRM_Survey_Findings_2014_Strategic-Benefits-Wellness-Initiatives.pdf (noting an increase in number of employers offering wellness programs, resources, or services to their employees increased from 70% in 2010 to 76% in 2014); See also *Workplace Wellness Programs are on the Rise-And Employers See Results*, SMALL BUS. TRENDS (Dec. 2, 2015), <http://smallbiztrends.com/2015/12/workplace-wellness-programs-rise.html>.
6. SOEREN MATTHE ET AL, RAND HEALTH, *Workplace Wellness Programs Study Final Report* 18-19 (2013), http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf (noting though percentages have fluctuated, in 2016 the Society for Human Resource Management found that 61% of surveyed employers provided wellness programs and 92% of employers provided some type of wellness benefit outside of a structured program).
7. Lisa Klautzer et al., *Can We Legally Pay People for Being Good? A Review of Current Federal and State Law on Wellness Program Incentives*, 49 INQUIRY 268, 268 (2012) (discussing the types of incentives offered by the Affordable Care Act).
8. RAND CORP., *DO WORKPLACE WELLNESS PROGRAMS SAVE EMPLOYERS MONEY?* (2014), available at http://www.rand.org/content/dam/rand/pubs/research_briefs/RB9700/RB9744/RAND_RB9744.pdf; Amy Fischbach, *Rising Health-Care Costs Fuel Demand for Corporate Wellness Services*, CLUB IND. (Apr. 1, 2015), <http://clubindustry.com/studies/rising-health-care-costs-fuel-demand-corporate-wellness-services>.
9. Rachel E. Silverman, *Employers Cut Down on Wellness Benefits*, WALL ST. J. (June 20, 2016, 10:05 AM), <http://www.wsj.com/articles/employers-cut-down-on-wellness-benefits-1466395262>.

seasonal flu vaccines, are declining in popularity.¹⁰ A closer look at the data reveals that companies may be becoming more strategic about selecting the programs that are likely to have the best return on investment, foregoing programs that they perceive to be less effective based on economic analysis.¹¹ This evidence strongly suggests that employers want to improve the benefits they provide, but this desire prompts the question: are the wellness programs becoming more successful as a result?

Whether a program is successful depends entirely on how success is defined.¹² For the purposes of this Article, we will look at the delivery process, which focuses on how well wellness programs are reaching their intended beneficiaries.¹³ In other words, we ask not if the wellness program saves the employer money based on return on investment, which is unquestionably important, but whether the program succeeds at enacting the intended behavioral modifications in the target populations.

Keeping this metric in mind, the effectiveness of wellness programs as a whole is unclear. Little peer-reviewed research has convincingly shown that wellness programs are evidence-based and successful.¹⁴ In fact, a growing body of literature suggests that wellness programs in their most common forms are generally not optimally designed to promote employee health.¹⁵ Moreover, many studies citing successful programs are suspect after critics pointed to flawed research methodologies and the fact that the same companies that administer the wellness programs often fund the research, creating an obvious conflict of interest.¹⁶

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10. SOC'Y FOR HUMAN RES. MGMT., 2016 EMPLOYEE BENEFITS: LOOKING BACK AT 20 YEARS OF EMPLOYEE BENEFITS OFFERINGS IN THE U.S. (2016), *available at* <https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2016%20SHRM%20Employee%20Benefits%20Full%20Report.pdf> (noting that "some types of wellness programs have decreased in popularity over the past one to five years, which could be an indication that organizations are being more strategic in selecting effective wellness programs for their employees").
 11. *Id.*
 12. Ron Z. Goetzel et al., *Do Workplace Health Promotion (Wellness) Programs Work?*, 56 J. OCCUPATIONAL & ENVTL. MED. 927, 928-929 (2014), (noting that three potential metrics exist for measuring the effectiveness of wellness programs: program structure, delivery process, expected utilization and cost, and productivity outcomes).
 13. *Id.* at 929.
 14. *Id.* at 927.
 15. Goetzel et al., *supra* note 12, at 931 (citing Laura Linnan et al., *Results of the 2004 National Worksite Health Promotion Survey*, 98 AM. J. PUB. HEALTH 1503, 1503-1509 (2008) ("Linnan et al., in a federally funded study published in 2008, found that just 6.9% of US employers offer comprehensive worksite health promotion programs as defined by the five elements listed in the *Healthy People 2010*.")).
 16. Alfred Lewis et al., *Employers Should Disband Employee Weight Control Programs*, 21 AM. J. MANAGED CARE e91, e91-e94 (2015) (discussing how studies have failed to show that wellness programs have been successful using valid metrics); *See also*

Worse still, the manner in which these programs most commonly fail can be discriminatory against certain groups, such as low-income earners.¹⁷ The question for this Article, then, is why some wellness programs fail to improve health among certain employee groups. And, if we can identify the reasons they fail, how can we design them to succeed?

We propose that some wellness programs fail because not all employees are equally situated to make healthier choices. An effective behavioral intervention must alter behavior. Though this statement seems obvious, the factors controlling a health intervention's ultimate success are complex and often difficult to discern. Wellness programs aspire to encourage employees to make healthier decisions, such as quitting smoking, eating better, and exercising more.¹⁸ However, in adopting this goal, the creators of wellness programs are making an important underlying assumption: employees have the ability to make meaningful choices about their health. When participating in a wellness program requires control over health-related decisions, there is a presumption that the participant has the autonomy necessary to decide between two or more options. However, the recent literature surrounding the social determinants of health demonstrates that socioeconomic factors and structural barriers may thwart efforts to adopt healthier behaviors.¹⁹ Thus, because the social determinants of health constrain certain people's ability to make healthier choices, behavioral interventions may not impact those individuals, resulting in unsuccessful wellness programs.

Assuming autonomy is one reason why many common wellness incentives may fail to alter the behavior of particular populations. But all is not lost. Assuming autonomy is a frequent characteristic—not a requirement—of wellness programs. Savvy designers can create wellness programs that do not assume autonomy, but rather enhance it. Thus, this Article contributes to the discussion surrounding wellness programs by exploring employee-level factors that impact program effectiveness and by suggesting ways to improve program design. In doing so, we recommend

Sharon Begley, *Do Workplace Wellness Programs Improve Employees' Health*, STAT (Feb. 19, 2016), <http://www.statnews.com/2016/02/19/workplace-wellness-programs-employee-health/> (Stating that, "while workplace wellness programs have been around for more than 20 years, there is a startling lack of rigorous evidence that they achieve their stated goals.").

17. Jill R. Horwitz et al., *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFF. 468, 469 (2013) (Stating that, "[s]ince low-income workers disproportionately suffer from conditions typically targeted by health-contingent programs, savings arising outside of health improvement may entail hidden, regressive redistributions, increasing the burden imposed on low-income workers.").
18. Larry Hand, *Employer Health Incentives*, HARV. SCHOOL PUB. HEALTH (2009), <https://www.hsph.harvard.edu/news/magazine/winter09healthincentives/>.
19. Laura McGovern et al., *Health Policy Brief: The Relative Contribution of Multiple Determinants of Health Outcome*, HEALTH AFF. (Aug. 21, 2014), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf.

concrete solutions to address the low engagement of certain employees and consequent lack of health improvement over the course of a wellness program.

This Article proceeds in three parts. Part I describes wellness programs in the context of the ACA and their overall effectiveness at improving employee health. Part II examines wellness programs as a behavioral intervention and suggests that the ineffectiveness of these programs stems in part from assuming the autonomy of program participants. We then argue that, by assuming autonomy, wellness programs disregard the very real effects of the social determinants of health. Part III offers autonomy-enhancing solutions to improve wellness programs that would provide meaningful choices to employees.

I. Wellness Programs & the Affordable Care Act

The ACA created incentives for employers to adopt wellness programs.²⁰ While the statute requires that wellness programs be reasonably designed to improve health and prevent disease, there is little research that supports their effectiveness.²¹ Part I details the ACA's wellness incentives and reviews the literature evaluating these programs. It ends by concluding that these programs may fail to reach low-income earners, a population that frequently has the poorest health and is most in need of health interventions.

A. ACA's Wellness Program Incentives

One of the more controversial provisions of the ACA is the employer mandate. It requires that businesses with fifty or more full-time equivalent employees provide health insurance to at least ninety-five percent of their full-time employees and their dependents up to the age of twenty-six or pay a fee.²² Many companies anticipated a spike in costs as a result and planned efforts to curb costs accordingly.²³

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20. U.S. DEP'T LABOR, FACT SHEET: THE AFFORDABLE CARE ACT AND WELLNESS PROGRAMS (Oct. 17, 2014), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/fswellnessprogram.pdf>.
 21. SOC'Y FOR HUMAN RES. MGMT., *supra* note 10.
 22. Patient Protection and the Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 253-56 (codified as amended at 26 U.S.C. § 4980H); Linda J. Blumberg, John Holahan & Matthew Buettgens, *Why Not Just Eliminate the Employer Mandate?*, URB. INST. (May 9, 2014), <http://webarchive.urban.org/UploadedPDF/413117-Why-Not-Just-Eliminate-the-Employer-Mandate.pdf> (addressing concerns with several aspects of the provision, including that it could cause companies to conduct widespread layoffs, reduce hours, create a disincentive for corporate growth, and involve high cost with questionable benefit).
 23. *Employer Mandate: What is the Employer Mandate?*, U.S. CHAMBER COMMERCE, <https://www.uschamber.com/health-reform/employer-mandate> (last visited Apr. 1, 2017) (stating that the mandate went into effect in 2015); Sheila E. Woodhouse & Stacey LaRue, *The Health Mandate*, VOLUNTARY BENEFITS MAG. (Sept. 6, 2012), <http://www.voluntarybenefitsmagazine.com/article/the-health->

Given the cost of health insurance per employee, both actual and predicted, it comes as no surprise that employers have an interest in promoting employee health to contain healthcare costs. By improving employee health metrics, employers aim to reduce healthcare consumption and reduce the amount of risk associated with the employee-risk pool upon which their insurance premiums are based.²⁴

One of the most common methods to address employee health is wellness programs.²⁵ In general, these programs aspire to empower employees to take ownership over their health and to participate in activities to improve their well-being.²⁶ By encouraging employees to develop and maintain healthy habits, the prediction is that employees will become healthier and consume less healthcare, decreasing the costs of health insurance.²⁷ In the best-case scenario, the result would be healthier employees with fewer health expenditures, reduced absenteeism, and increased morale, all of which would benefit the company's financial bottom line.

This model of disease prevention is especially attractive in the United States, a country that, for better or worse, considers personal responsibility for individual health paramount and where employer-sponsored health insurance dominates the market.²⁸ Wellness programs further American ideals by serving the dual purpose of encouraging personal responsibility while simultaneously reducing an individual's financial burden on her health plan.

These wellness programs have been around for many years, though interest has grown in the current climate of rising health costs, worsening population health, and recent changes in the laws governing health programs.²⁹ Yet regulating these programs is not new either, originating with the 1996 Health Insurance Portability and Accountability Act ("HIPAA").³⁰ The ACA further incentivized wellness programs in several provisions, ranging from start-up grants to small firms, a multi-state demonstration program for wellness-program participation in the

mandate.html (discussing wellness programs as a means of controlling health care costs).

24. See Jessica L. Roberts & Elizabeth Weeks Leonard, *What Is (and Isn't) Healthism*, 50 GA. L. REV. 833, 866-867 (2016).

25. Goetzel et al., *supra* note 12, at 927-928.

26. *Id.*

27. *Id.*

28. See Nicole Huberfeld & Jessica L. Roberts, *Health Care & the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 5 (2016) (describing the self-reliance narrative in American health care).

29. Klautzer et al., *supra* note 7, at 268.

30. Horwitz et al., *supra* note 17, at 469 (citing the Health Insurance Portability and Accountability Act of 1996).

individual market, and a technical-assistance role for the Centers for Disease Control and Prevention (“CDC”).³¹

Wellness programs may differ in a variety of ways. First, they can be participatory, health-contingent, activity-only, or outcome-based.³² HIPAA makes it easier for health plans to encourage participation in wellness programs but more difficult to reward employees for achieving a plan-specified health outcome, i.e. smoking cessation or a weight-loss goal.³³ The relative ease of enforcing between participation-based programs is deliberate, with an eye to preventing discrimination against workers who, for whatever reason, cannot or will not obtain or maintain a health goal specified by the program.³⁴ Despite the clear preference in the law for participation-based options, in 2015, forty-four percent of employers chose to offer outcome-based programs.³⁵

Second, the manner in which the program supports or promotes healthy behavior can vary. These options include telephone- or web-based support of health goals, educational materials and seminars, step challenges using pedometers, and biometric screenings.³⁶ Many programs also provide subsidized gym memberships and gift cards to healthy grocery stores.³⁷

Third, data about individual employees may be collected through any combination of methods, including online surveys, blood tests, and

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31. Klautzer et al., *supra* note 7, at 268 (citing 42 U.S.C. § 280l (Technical Assistance for Employer-based wellness programs)); 42 U.S.C. § 300gg-4(l) (Wellness program demonstration project); 42 U.S.C. § 280l: US Code – Notes (Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs)).
 32. 26 C.F.R. § 54.9802-1(f)(ii)-(v) (2016) (defining participatory, health-contingent, activity-only, and outcome-based wellness programs, respectively).
 33. Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359 NEW ENG. J. MED. 192, 193 (2008).
 34. See Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33,158, 33, 158 (June 3, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).
 35. Jack Craver, *Are Employers Afraid of Outcome-Based Wellness Programs?*, BENEFITSPRO (Sept. 30, 2015), <http://www.benefitspro.com/2015/09/30/are-employers-afraid-of-outcome-based-wellness-pro?slreturn=1469494999>.
 36. Bard, *supra* note 4, at 471.
 37. Julia James, *Health Policy Brief: Workplace Wellness Programs*, HEALTH AFF. (May 16, 2013), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_93.pdf (Stating that, “[t]ypical features of wellness programs are health-risk assessments and screenings for high blood pressure and cholesterol; behavior modification programs, such as tobacco cessation, weight management, and exercise; health education, including classes or referrals to online sites for health advice; and changes in the work environment or provision of special benefits to encourage exercise and healthy food choices, such as subsidized health club memberships.”).

wearable devices.³⁸ This data collection allows companies to make decisions about premium discounts and surcharges, as well as provides the employee with necessary information to identify preventable diseases before their onset.³⁹ These data also inform the company of the health of its workers in the aggregate.⁴⁰ Some employees feel that data collection methods, such as biometric screening, are suspect and have tried—and largely failed—to challenge wellness data collection using antidiscrimination statutes such as the Americans with Disabilities Act (“ADA”) and the Genetic Information Nondiscrimination Act (“GINA”).⁴¹

Fourth, employers can design their wellness programs to adjust the percentage of healthcare premiums paid by employees either to encourage participation or to force employees to meet a specified health outcome. This practice, however, does have its limits. Federal regulations raise the maximum amount an employer can offer financial incentives for participating in wellness programs from twenty percent to thirty percent of the cost of coverage.⁴² This amount increases to fifty percent for programs specifically designed to decrease or to eliminate tobacco use.⁴³ Employers

38. Dinah Wisenberg Brin, *Wellness Programs Raise Privacy Concerns over Health Data*, SOC’Y HUMAN RES. MGMT. (Apr. 6, 2016), <https://www.shrm.org/resourcesandtools/hr-topics/technology/pages/wellness-programs-raise-privacy-concerns-over-health-data.aspx>.

39. Bard, *supra* note 4, at 475, 478.

40. Rachel E. Silverman, *Bosses Tap Outside Firms to Predict Which Workers Might Get Sick*, WALL ST. J. (Feb. 17, 2016, 7:58 PM), <http://www.wsj.com/articles/bosses-harness-big-data-to-predict-which-workers-might-get-sick-1455664940>.

41. EEOC v. Flambeau, Inc., 131 F. Supp. 3d 849, 851, 855 (W.D. Wis. Dec. 30, 2015) (alleging violations of the ADA); EEOC v. Honeywell Int’l Inc., No. 14-4517 ADM/TNL, 2014 WL 5795481, at *1, *2 (D. Minn. Nov. 6, 2014) (alleging violations of the ADA and GINA).

42. 45 C.F.R. § 146.121(f)(5) (2015); *See also* 42 U.S.C. § 300gg-4(j)(3)(A) (2015) (Stating that, “[t]he reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate”).

43. 42 U.S.C. § 300gg-4(j)(3)(A) (2015).

have the discretion to use incentives, such as discounts and gift cards, or penalties, such as surcharges, but the benefits provided cannot exceed the statutorily mandated caps.⁴⁴ These carve-outs could disproportionately disadvantage some employees based on health.⁴⁵ Moreover, intentionally or not, these practices may penalize the employees most in need of health interventions and overburden those employees who may already be in financially difficult situations.⁴⁶

These options in wellness-program design create an environment where employers can influence or coerce employees to participate. This effect is especially true for low-income workers who may not view the income difference created by the incentives or penalties as optional and who may not fully appreciate the potential privacy hazards created by data collection and participation.⁴⁷

B. Effectiveness of Wellness Programs

Following the ACA, a health-contingent or outcome-based wellness program must be:

reasonably designed to promote health or prevent disease. A program complies with this requirement if it (1) has a reasonable chance of improving the health of, or preventing disease in, participating individuals; (2) is not overly burdensome; (3) is not a subterfuge for discrimination based on a health factor; and (4) is not highly suspect in the method chosen to promote health or prevent disease.⁴⁸

Notable among these requirements is that wellness programs must have a reasonable chance of success.

Encouraging people to make healthier choices is a worthwhile policy goal. Healthy lifestyle changes, such as increasing physical activity, correlate with positive health outcomes for people who are able to maintain healthy

44. *Id.*; See also Karen Pollitz & Matthew Rae, *Workplace Wellness Programs Characteristics and Requirements*, KAISER FAM. FOUND. (May 19, 2016), <http://kff.org/private-insurance/issue-brief/workplace-wellness-programs-characteristics-and-requirements/> (noting that incentives often come in the form of “cash, gift cards or other merchandise”).

45. Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571, 590-592 (2014) (discussing the term “healthism” as unfair discrimination on the basis of health status).

46. Roberts & Leonard, *supra* note 24, at 893-94.

47. Harald Schmidt et al., *Carrots, Sticks, and Health Care Reform—Problems with Wellness Incentives*, 362 NEW ENG. J. MED. e3(1), e3(2)-e3(3) (2010); See also Kristen Madison et al., *The Law, Policy, and Ethics of Employer’s Use of Financial Incentives to Improve Health*, 39 J. L. MED ETHICS 450, 456 (2011).

48. 29 C.F.R. § 2590.702(f)(3)(iii) & (f)(4)(iii) (2015); See also 26 C.F.R. § 54.9802-1(f)(3)(iii) & (f)(4)(iii) (2015); 42 U.S.C. § 300gg-4(j)(3)(B) (2015); 45 C.F.R. § 146.121(f)(3)(iii) & (f)(4)(iii) (2015).

behavioral modifications over time.⁴⁹ For example, adults participating in consistent physical activity have been shown to exhibit a twenty- to thirty-percent reduction in risk for premature death and up to a fifty-percent reduction in chronic conditions such as diabetes or cancer.⁵⁰ However, despite the widespread information available on the benefits of adopting healthy behaviors, adults do not always make decisions that are in the best interest of their overall health. Anyone who has ever attempted to make a substantial healthy change in their own life is familiar with the inherent difficulties in adopting healthy behaviors over the long term. Promoting lasting changes in health behavior is then of interest to health insurers and employers who may ultimately pay for bad health outcomes on the back end.

As noted, employers have significant leeway in designing wellness programs to fit their corporate culture and beneficiary needs.⁵¹ Unfortunately, some of these programs have been described as poorly designed, haphazard, not evidence-based, inadequately resourced, not culturally supported, and ineffective.⁵²

For example, losing weight and smoking cessation are common health goals for wellness programs.⁵³ Despite their ubiquity, weight-loss and smoking-cessation programs have low success rates, both on the individual and group level.⁵⁴ Even reports of allegedly successful weight-loss programs have severe study errors, including only documenting active participants who succeeded in achieving health goals and ignoring control groups, drop-outs, nonparticipants, and those who failed to achieve the specified health outcome.⁵⁵ Other common criticisms of alleged program success are that wellness-program vendors and administrators sponsor the research and that any measurable improvement in health-related behavior is, at best, small in size.⁵⁶ Other sources show, after examining ten years of data, the

49. Mary E. Patay et al., *Understanding Motivators and Barriers to Physical Activity*, 72 THE PHYSICAL EDUCATOR 494, 497 (2015).

50. *Id.*

51. INST. HEALTH & PRODUCTIVITY STUD. JOHNS HOPKINS BLOOMBERG SCH. PUB. HEALTH ET AL., FROM EVIDENCE TO PRACTICE: WORKPLACE WELLNESS THAT WORKS, (Sept. 2015), *available at* <https://www.transamericacenterforhealthstudies.org/docs/default-source/wellness-page/from-evidence-to-practice---workplace-wellness-that-works.pdf?sfvrsn=2>.

52. Goetzel et al., *supra* note 12, at 927.

53. Pollitz & Rae, *supra* note 44 (noting that 50% of firms offering health benefits in 2015 offered wellness programs related to “tobacco cessation,” “weight loss,” and/or “other lifestyle or behavioral coaching”).

54. Lewis et al., *supra* note 16, at e91.

55. *Id.* at e92.

56. Begley, *supra* note 16.

return on investment is an abysmal fifty cents per every dollar spent on the program.⁵⁷

With conflicting information about the success of these programs, there are understandable concerns about their success in populations at higher risk of poor health. Unfortunately, little data show the specific impact of wellness programs on minority populations. However, research shows that these programs tend to have more engagement and success in populations that are already healthy, that are classified as white-collar workers, that hold management-level positions, and that have obtained higher levels of education.⁵⁸ Common indicators of poor health, such as obesity and unhealthy diet, are more common among individuals in lower socioeconomic groups, including the ones least likely to be engaged in wellness programs.⁵⁹ These lower-income groups also comprise the largest percentage of the working population.⁶⁰ Moreover, low-income workers often overlap with historically disadvantaged minority populations. The net worth of white Americans is over fifteen times the net worth of black Americans and over thirteen times the net worth of Hispanic Americans.⁶¹

Other scholars have expressed concern about the potential negative impact of wellness programs on these vulnerable populations. Jill Horwitz has theorized that the savings resulting from these programs may be the result of cost-shifting from healthy workers to unhealthy workers.⁶² This possibility is concerning because the conditions these programs target are most prevalent in lower socioeconomic classes.⁶³ As she notes, “since low-income workers disproportionately suffer from conditions typically targeted by health-contingent programs, savings arising outside of health improvements may entail hidden, regressive redistributions, increasing the burden on low-income workers.”⁶⁴

57. RAND, *supra* note 8.

58. Sharon E. Thompson et al., *Factors Influencing Participation in Worksite Wellness Programs Among Minority and Underserved Populations*, 28 FAM. CMTY. HEALTH 267, 268-269 (2005).

59. Jean Adams et al., *Why Are Some Population Interventions for Diet and Obesity More Equitable and Effective than Others? The Role of Individual Agency*, 13 PLOS MED., 1 (2016) (stating that, “obesity and unhealthy diets are more common in more socioeconomically disadvantaged groups,” and that “socioeconomic inequalities in health and disease are at least partly due to these inequalities in diet and obesity”).

60. *Distribution of Nonelderly Adult Workers by Occupational Category*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/blue-and-white-collar-workers/> (last visited Apr. 1, 2017).

61. Steven H. Woolf & Jason Q. Purnell, *The Good Life: Working Together to Promote Opportunity and Improve Population Health and Well-Being*, 315 J. AM. MED. ASSOC. 1706, 1706 (2016).

62. Horwitz et al., *supra* note 17, at 468-469.

63. *Id.* at 473.

64. *Id.* at 469.

Sadly, socioeconomically disadvantaged groups are less healthy than their wealthy counterparts.⁶⁵ Yet if there is so much room for improvement in the health of these groups, and if health is indeed simply a matter of information and choice, why are wellness programs failing among the least healthy populations? And why are we not seeing better outcomes in wellness programs generally? The problem may lie in the underlying assumption that, if given the opportunity, education, and encouragement, an employee will make healthy choices. While this assumption may be true for some, as we explain, it has obvious shortcomings for many workers.

II. The Autonomy Assumption in Wellness Programs

As discussed, one primary function of wellness programs is to encourage employees to make healthier choices in their individual lives, both inside and outside the workplace.⁶⁶ However, for an employee to make good choices, they must first have options. Part II of this Article examines the role of choice in wellness programs through the framework of libertarian paternalism or “nudges.” Nudges seek to correct behavioral market failures by encouraging individuals to act in their own best interest.⁶⁷ As nudges, wellness programs rely on their participants making better choices. In so doing, they assume autonomy, i.e. the ability to choose for oneself. However, socioeconomic and structural factors may limit an individual’s ability to make healthy choices. Part II demonstrates how the social determinants of health can limit autonomy, effectively removing choice. If a person’s unhealthy behavior results from external, as opposed to internal, factors, she cannot be nudged and the wellness program will not have its desired impact.

A. Role of Choice in Wellness Programs

Despite their diversity in content and composition, most wellness programs share common attributes, including screenings to identify health risks, a focus on preventive interventions, and a vocal commitment to health promotion.⁶⁸ Wellness programs may offer employees a wide variety of incentives, either for merely participating or for reaching certain health outcomes. Common incentives include cash prizes, novelty items like t-shirts, tickets to events, and coffee mugs, free or discounted gym memberships, and premium reductions.⁶⁹ By helping employees identify their areas of health risk and by offering rewards for taking actions to

65. Adams et al., *supra* note 59, at 1.

66. McGovern et al., *supra* note 19.

67. *See infra* note 71.

68. HAP.ORG, WORKSITE WELLNESS WORKBOOK: A STEP-BY-STEP GUIDE AND RESOURCES FOR DEVELOPING A WORKSITE WELLNESS PROGRAM FOR YOUR ORGANIZATION, ii (2013) *available at* https://www.hap.org/employers/worksite/pdfs/Workbook_2013.pdf.

69. MATTKE ET AL., *supra* note 6, at 71-73.

reduce those risks, wellness programs hope to influence and ultimately change bad health habits. For wellness programs to be effective, though, they *must be capable of inducing employees to modify their behaviors or choices*.⁷⁰ If the program fails to modify behavior, it will be ineffective.

Viewing wellness programs as behavioral interventions situates them within a greater movement to target behavioral market failures using behavioral economics.⁷¹ It goes without saying that people do not always make decisions based on their best interests or rational judgment. In their highly influential book *Nudge*, Richard Thaler and Cass Sunstein assert that people make decisions that fail to serve their long-term interests under predictable sets of circumstances, such as (1) when the decisions test their self-control, (2) when the decisions are difficult, (3) when the decisions do not allow individuals to learn from their past experiences, and (4) when the decisions are unfamiliar.⁷² According to the field of behavioral economics, individuals fail to act in their own rational, long-term self-interest due to a variety of cognitive quirks, including bias in favor of present (rather than future) interests, the tendency to ignore shrouded but important information, unrealistic optimism, and difficulties understanding statistical probabilities.⁷³ As human beings, we are all vulnerable to status-quo bias, temptations, and automatic thinking.⁷⁴ Because these cognitive tendencies and biases distort decision-making, they generate behavioral market failures when they lead people to make choices that do not serve their rational, long-term interests.

Thaler and Sunstein believe that these behavioral market failures are correctable and that individuals can be encouraged—or nudged—to make better choices.⁷⁵ They assert that it is not only permissible, but ethically

70. Horwitz et al., *supra* note 17, at 471 (emphasis added).

71. See RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2009); CASS R. SUNSTEIN, *WHY NUDGE? THE POLITICS OF LIBERTARIAN PATERNALISM* 34-50 (2015). Wellness programs are frequently described as nudges. See, e.g., Ellen Chang, *Why Current Corporate Wellness Programs Are Not Nudging Employees Out of Their Chairs*, MAINSTREET.COM (Feb. 6, 2016), <https://www.mainstreet.com/article/why-current-corporate-wellness-programs-are-not-nudging-employees-out-of-their-chairs>; Peter Saravis, *Engaging Employees with a Healthy Nudge*, TRAININGMAG.COM (Feb. 11, 2013), <https://trainingmag.com/content/engaging-employees-healthy-nudge>; Peter Saravis, *Wellness Programs: 6 Ways to 'Nudge' Employees Toward Better Health*, HRBENEFITSALERTS.COM (Sept. 19, 2012), <http://www.hrbenefitsalert.com/wellness-programs-ways-nudge-employees/>; Prashant Srivastava, *How a Simple 'Nudge' Could Increase Employee Wellness Engagement and Reduce Wellness Program Costs*, VOLUNTARYBENEFITSMAGAZINE.COM (Dec. 8, 2011), <http://www.voluntarybenefitsmagazine.com/article-detail.php?issue=issue-30&article=how-a-simple-nudge-could>.

72. MATTHEW ET AL., *supra* note 6, at 73-76.

73. SUNSTEIN, *supra* note 71, at 34-50.

74. *Id.* at 44.

75. See generally THALER & SUNSTEIN, *supra* note 71.

desirable, for a third party to influence choice to promote welfare.⁷⁶ As libertarian paternalists, Thaler and Sunstein's preferred vehicle for addressing behavioral market failures is "nudges."⁷⁷

To provide a working set of definitions, a nudge is "any aspect of the choice architecture that alters people's behavior in a predictable way without forbidding any options or significantly changing their economic incentives." For an intervention "[t]o count as a mere nudge, [it] must be easy and cheap to avoid."⁷⁸ A "choice architect" is any individual or entity that has control over the circumstances that influence decision-making.⁷⁹ Because nudges are, by definition, avoidable, individuals maintain freedom of choice, thus putting the "libertarian" in the concept of "libertarian paternalism."

In seeking to eliminate behavioral market failures, nudges target only "the kinds of situations in which people are least likely to make good decisions."⁸⁰ Nudges include a variety of interventions, such as reminding people about the effects of their decisions on their long-term well-being, educating them to facilitate better decision-making, and offering rewards for behavioral changes.⁸¹ As such, nudges are policy interventions that seek to address the behavioral market failures that occur due to flaws in the human cognitive process. The nature of nudges, therefore, makes them well-suited to wellness programs and health improvement initiatives.

Wellness programs can then be understood as nudges designed to encourage healthy choices without eliminating options to make poor health choices.⁸² Regardless of whether a wellness program is participation- or outcome-based, success requires that the employee make decisions that result in better health outcomes. In the case of participation-only programs, failure to make healthy choices results in a waste of money on the part of the company. In the case of the outcome-based programs, the failure can result in financial harm to the employee in the form of penalties or missed opportunities for additional money. Central to either kind of program is the assumption that participants can make meaningful choices.

However, the more independent steps required to complete a health action required by a wellness program, the less likely it is to succeed.⁸³ For example, if a wellness program subsidizes gym membership, the success of that program requires that an employee understand the requirements for

76. See generally THALER & SUNSTEIN, *supra* note 71; see also Cass Sunstein & Richard Thaler, *Libertarian Paternalism*, 93 AM. ECON. REV. 175 (2003).

77. THALER & SUNSTEIN, *supra* note 71.

78. *Id.*

79. *Id.* at 3.

80. *Id.* at 74.

81. *Id.* at 7.

82. *Id.* at 6.

83. *Id.* at 62.

a subsidized membership, obtain reliable transportation to the gym, and repeatedly go. These requirements are further complicated when individuals need to arrange for childcare, work multiple jobs, or feel too intimidated to enter a gym in light of their current health status. Attrition can be expected at each discrete step.⁸⁴ Put simply, the more personal agency an intervention requires, the less likely it is to be effective.

In sum, as nudges, wellness programs seek to address human cognitive quirks to improve health-related decision-making. But nudges are only a part of the equation. While nudges may be effective in addressing behavioral market failures, not all poor health-related decisions result from succumbing to status-quo bias, temptation, or automatic thinking. Some individuals will not make the most healthful decision even when presented with complete information, unlimited cognitive abilities, and unwavering self-control. People may make poor decisions because there is no meaningful choice to be made. We argue that advocates of wellness programs assume that an individual is capable of choosing a healthy option without taking into account how socioeconomic factors and structural barriers may limit the available choices. Wellness programs may fail to influence employee behavior when unhealthy choices are the result of external, not internal, factors.

B. Social Determinants of Health

Advocates of personal responsibility frequently blame people for their poor health.⁸⁵ Popular narratives in the United States surrounding self-reliance and personal responsibility presuppose that an individual's health is completely within her control. In other words, they assume that when she makes decisions about her health, she is acting autonomously. As a value, autonomy envisions human beings as independent actors capable of making unconstrained choices.⁸⁶ Americans tend to revere autonomy over equality,⁸⁷ a reality played out in the current popularity of nudges and their ability to influence decisions while preserving choice. However, as Martha Albertson Fineman has argued, far from being independent and unconstrained, human beings are by nature interdependent and limited by their circumstances.⁸⁸ Thus, she asserts autonomy is, at its core, a myth.

Though many things can influence health status, some of the most significant factors are social and economic.⁸⁹ Programs that target obesity and smoking by simply making available a health resource are focusing on

84. Adams et al., *supra* note 59, at 62.

85. Woolf & Purnell, *supra* note 61, at 1706.

86. MARTHA ALBERTSON FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY* xiii (2004).

87. Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State*, 60 EMORY L. J. 251, 258 (2011).

88. *See generally id.*

89. Michael Marmot & Jessica J. Allen, *Social Determinants of Health Equity*, 104 AM. J. PUB. HEALTH S517, S517 (2014).

a symptom and not a cause of poor health. The true cause of the health condition may not be bad habits but in the employee's socioeconomic and cultural reality: the social determinants of health. Progress will not be made until we focus on these root causes.⁹⁰ Hence, policymakers waste resources addressing the wrong problem.

The social determinants of health are broadly understood as the "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."⁹¹ The literature on the social determinants make the limits of autonomy in the context of health abundantly clear. Recent research indicates that factors outside individual control influence health.⁹² Socioeconomic and environmental conditions, including access to education, income, healthy foods, and safe recreational options, limit individuals' health choices.⁹³ A person's social and physical environments can limit her options and her available resources.⁹⁴ These structural barriers have led to growing health disparities between the rich and the poor.⁹⁵ Moreover, housing discrimination has limited people of color's access to health-promoting neighborhoods.⁹⁶ The resulting inequities in health can be seen on any scale: globally, nationally, individually, or even among a specific workforce.

The underlying assumption that employees have the power to change their health-related behaviors is not always fair or accurate.⁹⁷ Because policies designed to encourage or reward healthier lifestyle choices require the ability to choose, certain groups will face impediments to implementing

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90. Steven H. Woolf & Paula Braveman, *Where Health Disparities Begin: The Role of Social and Economic Determinants—And Why Current Policies May Make Matters Worse*, 30 HEALTH AFF. 1852 (2011).
 91. *Social Determinants of Health*, HEALTHY PEOPLE 2020 (Sept. 2, 2016), <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
 92. Woolf & Purnell, *supra* note 6185. Social determinants of health may in fact be the next frontier in health policy. *See, e.g.*, Jessica Mantel, *Taking Aim at the Social Determinants of Health: A Central Role for Providers*, GA. ST. L. REV. (forthcoming 2016).
 93. Marmot & Allen, *supra* note 89, at s517.
 94. Catherine Cubbin et al., *Where We Live Matters for Our Health: Neighborhoods and Health*, ISSUE BRIEF (2008), <http://www.commissiononhealth.org/PDF/888f4a18-eb90-45be-a2f8-159e84a55a4c/Issue%20Brief%203%20Sept%2008%20-%20Neighborhoods%20and%20Health.pdf>.
 95. WORLD HEALTH ORG., *Social Determinants of Health*, at 2-3, WHO Doc. EB132/14 (July 26, 2016).
 96. Cubbin et al., *supra* note 94.
 97. Roberts, *supra* note 45, at 615 (exploring the idea of voluntariness in the context of immutability of traits for discrimination purposes, and highlighting the importance of examining health behaviors in a more holistic manner.)

behavioral change.⁹⁸ When faced with obstacles to change, people often simply do not act.⁹⁹

Social determinants of health not only include the physical environment and socioeconomic factors, but also knowledge and behavior, both frequent targets of wellness programs. However, wellness programs that focus on education and behavioral change are often too far downstream of the real impediment to affect health-related decisions in a meaningful way.¹⁰⁰ Upstream social determinants, such as living conditions in homes and communities, play a more significant role and represent the best opportunity to influence health outcomes.¹⁰¹ Because they do not target the types of upstream factors that have the most impact on the ability to make better health-related decisions, downstream interventions common to wellness programs may fail.

For example, wellness programs that encourage healthy food choices are very common examples of interventions targeting a downstream determinant of health.¹⁰² Studies have shown that access to nutritious food can impact diet and diet-related health risks.¹⁰³ However, if an employer chooses to encourage healthy eating by providing gift cards to healthy grocery stores, the program may prove ineffective. A gift card will not make the healthy grocery store accessible or convenient if the employee is among the 23.5 million Americans that live in a food desert.¹⁰⁴ An employee's ability to pay for produce at the cash register is only one of several hurdles she may have to overcome to make healthier food choices.

98. *See id.* at 618.

99. *See* Madison et al., *supra* note 47, at 450 ("Individuals can often take steps to preserve or improve their own health But they often fail to take these steps."). For example, vulnerable groups experience unique barriers to quitting smoking. Laura Twyman et al., *Perceived Barriers to Smoking Cessation in Selected Vulnerable Groups: A Systematic Review of the Qualitative and Quantitative Literature*, 4 BRIT. MED. J. OPEN 1, 2 (2014) ("Within the health behaviour literature, factors that prevent an individual from undertaking health behaviour change have been referred to as barriers"); *see also* Merete Osler & Eva Prescott, *Psychosocial, Behavioural, and Health Determinants of Successful Smoking Cessation: A Longitudinal Study of Danish Adults*, 7 TOB. CONTROL 262, 265-66 (1998) (noting that a Danish study found that individuals with lower social status had greater difficulty quitting smoking regardless of their motivation to stop).

100. *See* Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 383 (2011); *see also* Woolf & Braveman, *supra* note 90, at 1852-54 (distinguishing between upstream and downstream determinants).

101. *See* Woolf & Braveman, *supra* note 90, at 1852-54.

102. *See* Lori Dorfman, *Moving Nutrition Upstream: The Case for Reframing Obesity*, 39 J. NUTR. EDUC. BEHAV. S46, S46 (2007).

103. Renee E. Walker et al., *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature*, 16 HEALTH & PLACE 876, 877 (2010).

104. U.S.D.A. REP. TO CONGRESS, ACCESS TO AFFORDABLE AND NUTRITIOUS FOOD: MEASURING AND UNDERSTANDING FOOD DESERTS AND THEIR CONSEQUENCES 22 (2009).

At the core of this example is the fact that the employee cannot make better choices with respect to food because there is no real choice to make. If the healthy grocery store is inaccessible, it will never be within the employee's power to decide whether to buy fresh produce at that location. The social determinants of the employee's health—e.g., that employee's neighborhood, income, family situation, work hours, etc.—remove meaningful choice from the equation. Harald Schmidt explains:

Some people share the desire for behavior change . . . but, for a range of reasons, may not act on it The reasons may stem from their everyday circumstances, such as poor availability of affordable or healthy food or insufficient time to prepare it. They may lack access and time for physical exercise in a safe environment. They may face above-average levels of professional or personal stress and resort to coping mechanisms such as smoking. Such factors can render outcome incentive programs, such as quitting smoking or achieving specific BMI values, significantly more challenging [E]ven process incentives such as lower health care costs in return for gym attendance may be taken up more readily by some than others. For many in this group, incentives may be extremely tempting, yet the amounts at stake can be as far out of reach as the branches of the fruit-laden trees were for the mythical Tantalus.¹⁰⁵

An employee who does not have the resources or ability to choose between healthy and less-healthy options will be helpless to enact healthful changes, regardless of how many perks are offered by an employer in an attempt to nudge her. If instead the employer provided a farmer's market option at the worksite or an end-of-day shuttle to the local health food store, choice would be reintroduced into the equation and the intervention could have the opportunity to succeed.

Literature describes "lifestyle drift" as "the tendency in public health to focus on individual behaviors, such as smoking, diet, alcohol, and drugs, that are undoubted causes of health inequities, but to ignore the drivers of these behaviors—the causes of the causes."¹⁰⁶ Wellness programs are a prime example of lifestyle drift in that they focus on the individual behaviors rather than the sources of the behaviors to address health problems. However, this focus misses opportunities to enact a real, sustainable change.

Thaler's and Sunstein's discussion of overweight people demonstrates how lifestyle drift plays out in the academic literature and reveals how framing issues in terms of behavioral market failures assumes that individuals are acting autonomously.¹⁰⁷ First, they "reject the claim that all

105. Harald Schmidt, *Wellness Incentives, Equity, and the 5 Groups Problem*, 102 AMER. J. PUB. HEALTH 49, 51 (2012).

106. Marmot & Allen, *supra* note 89, at s517.

107. THALER & SUNSTEIN, *supra* note 71, at 35.

or almost all Americans are choosing their diet optimally” without acknowledging that the suboptimal choices may be the result of a lack of resources.¹⁰⁸ Instead, they target herd mentality: “Obesity is contagious. If your best friends get fat, your risk of gaining weight goes up.”¹⁰⁹ We do not dispute that being overweight correlates with socializing with other overweight people. However, Thaler and Sunstein seem to be engaging in a causation-correlation fallacy. While human beings may “follow the herd,” we also tend to socialize with people who are in proximity to us, like family and neighbors. Perhaps then the reason that certain social groups tend to be overweight is not due to the norms within the group, but rather to a shared experience of living in a food desert or a fast-food swamp without opportunities for safe, affordable exercise.

Despite evidence pointing to the real causes of poor health, employers persist in discriminating against those employees who are unable to comply with wellness programs.¹¹⁰ This noncompliance further stigmatizes those employees and can, in some cases, exclude them from necessary programs by turning the focus on their own failure to adopt healthier habits, rather than larger societal contributors to their health statuses.¹¹¹ While employers may have justifiable reasons for focusing on the health of employees, they can ultimately perpetuate existing health disparities, especially among historically disadvantaged groups, such as racial and ethnic minorities, the disabled, and the poor.¹¹² Employees in these social categories are more likely to use tobacco products and be overweight, while simultaneously encountering barriers to making healthy decisions and lifestyle changes.¹¹³ As a result, efforts to improve health can have the opposite effect, by not only decreasing pay for those already in need when they fail to succeed in the wellness program, but also by excluding them from access to needed health interventions.¹¹⁴

In short, wellness programs that provide gift cards to grocery stores will fail to influence behavior when the grocery store is far away and the employee has no reliable access to transportation. Subsidized gym memberships mean little to an employee who works two jobs or cannot secure dependable childcare. Step challenges will not be effective at encouraging active lifestyles if an employee is unable to afford a pedometer, unable to walk while at work, or lives in a poorly lit neighborhood with a high crime rate and unmaintained sidewalks. If employers hope to save money by reducing health care expenditures, it

108. *Id.* at 7.

109. *Id.* at 55.

110. Roberts, *supra* note 45, at 626.

111. Roberts & Leonard, *supra* note 24, at 866-867.

112. Roberts, *supra* note 45, at 616.

113. *Id.*

114. *Id.* at 625.

would serve them well to consider the factors that truly impact the health choices of their employees.

III. Autonomy-Enhancing Policy Solutions

Regardless of their good intentions, wellness programs may be functionally excluding the very employees who could benefit most. In the process, employers may be wasting money on programs that do not improve health outcomes, in turn undermining their desire to improve health and lower costs. This Part argues that by increasing autonomy, wellness programs can achieve better outcomes. Specifically, it proposes that by incorporating healthy behaviors and choices into the workday, employers can increase the success of their wellness initiatives.¹¹⁵

Again, Fineman's work in this area is instructive. While she has written primarily about the need for a responsive state,¹¹⁶ her insights are likewise applicable to the context of private wellness programs. Instead of adopting policies that view autonomy as inherent to the human condition, Fineman advocates policies that seek to create autonomy.¹¹⁷ According to this view, autonomy is not innate but rather aspirational. We therefore advocate that employers move away from interventions that assume their employees have access to meaningful choices and instead provide those choices directly, serving to *enhance*—instead of *assume*—autonomy. Interventions that require the least amount of agency tend to be effective and more equitable.¹¹⁸

There are many examples of employers successfully bringing healthy behaviors and choices to the workplace. For example, Chesapeake Energy Corporation established a healthcare center at its Oklahoma City headquarters that offers a robust array of health services.¹¹⁹ In partnership with St. Anthony's Hospital, it provides employees and dependents primary care, urgent care, and disease management for a mere five dollar copay.¹²⁰

115. Chang, *supra* note 71 (citing to a conversation with Jonathan Webb, vice president of business markets for KI—a company that has noted financial benefit in offering wellness at the worksite—in which he notes that “the workplace is such an incubator for sedentary behavior,” and that “if [employers] build walking paths and stairs, employees will use them”).

116. *See generally* Fineman, *supra* note 87.

117. *Id.* at 260 (Explaining that autonomy “cannot be attained without an underlying provision of substantial assistance, subsidy, and support from society and its institutions, which give individuals the resources they need to create options and make choices.”).

118. Adams et al., *supra* note 59, at 2.

119. Stacy Perman, *Corporate America Wants to Help You Lose Weight*, BUSINESSINSIDER.COM, (July 26, 2011, 5:54 PM), <http://www.businessinsider.com/corporate-american-health-care-wellness-programs-2011-7>.

120. *Id.*

Additionally, Chesapeake brought fitness to the workplace by building a 72,000 square foot fitness center staffed with personal trainers that includes an Olympic-sized swimming pool and rock wall.¹²¹ Another company following this gold standard of bringing wellness to work is Scott's Miracle Grow, a company that built a multi-million dollar gym across the street from their headquarters and offers free prescription drugs from a drive-thru.¹²²

Yet employers need not break the bank building brand-new facilities or offering concierge care to bring healthy choices to the workplace. Other companies, such as Kaiser Permanente, have made healthy foods accessible by hosting farmers' markets at select locations.¹²³ Some companies simply offer yoga classes to manage stress or extend lunch hours to allow employees to go for a walk.¹²⁴ Others still construct their office with the goal of health, offering desks that allow occupants to be active using a pedaling mechanism, a treadmill, or simply standing.¹²⁵

Not every company needs to be a Scott's Miracle Grow or Chesapeake Energy to reap the benefits of a successful wellness program. To overcome the impact of the social determinants of health on employee choice, wellness programs must be designed to enhance autonomy by reducing the amount of personal resources required to participate. Specifically, allowing employees to make as many healthy choices at work as possible and at little personal cost may improve employee engagement and health outcomes. If companies wish to see successful programs that have real impact on health expenditures, it would serve them well to create a culture of health at the worksite, incorporating the behaviors and choices they wish employees to adopt into the workday.

Conclusion

Despite their popularity and ubiquity, wellness programs may not always successfully nudge employees toward making healthier choices. These failures could be due in part to the assumption that health-related decisions are within an individual employee's control. However, the recent literature surrounding the social determinants of health reveals that many

121. Tera Kristen, *6 Examples of Workplace Wellness Programs*, RISE (Mar. 16, 2016), <https://rise.xyz/blog/workplace-wellness-programs/>.

122. Michelle Conlin, *Get Healthy or Else: Inside One Company's All-Out Attack on Medical Costs*, BLOOMBERG.COM (Feb. 25, 2007), <http://www.bloomberg.com/news/articles/2007-02-25/get-healthy-r-else>.

123. Mary MacVean, *Kaiser Permanente Farmers Markets Put Nutrition Within Reach*, L.A. TIMES (May 20, 2009), <http://www.latimes.com/food/la-fo-kaiser20-2009may20-story.html>.

124. Kristen, *supra* note 121.

125. See Dana Blankenhorn, *Can a Treadmill Desk Save Your Life*, MAINSTREET.COM, (Jan. 23, 2014, 10:43 AM), <https://www.mainstreet.com/article/can-treadmill-desk-save-your-life>.

Americans are constrained by socioeconomic factors that limit their ability to make decisions in their best interest. Until the designers and administrators of wellness programs recognize the barriers to healthy choices, wellness programs could continue to fail employees who are most in need. This Article proposes that careful design and consideration can help wellness programs overcome some common barriers to adopting healthy behaviors. In turn, these modifications will improve health outcomes for employees by creating meaningful choices where none had existed before.

