Public Comment - Do No Harm: Avoiding Discrimination and Ensuring Wellness Programs Comply with Federal Equal Employment Opportunity Laws

TO: Equal Employment Opportunity Commission

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We the undersigned are deeply concerned that wellness programs utilizing fees or withholding financial rewards could disproportionately impact groups protected under discrimination law. This is a major civil rights issue that impacts members of several protected categories and threatens to undermine the general health and wellness of people of all sizes.

Wellness programs that require disclosure of medical history/status or require the achievement of specific biological markers in order to avoid higher premiums disproportionately impact those who already suffer from discriminatory practices: women, people with disabilities, older people, members of certain racial and ethnic minorities, and people at lower income levels. The same populations that are likely to be discriminated against in housing, employment, education and healthcare are the groups disproportionately impacted by discriminatory wellness programs.

Wellness programs that target weight metrics* and penalize people based on higher weight metrics will disproportionately punish members of protected categories. Women live longer than men[1] and are therefore more likely to have diseases that are more common in older age, but they also receive a lower average wage than men,[2] so that any given financial incentives/penalties have a much greater impact on women. Women also face more weight prejudice than men. Individuals of African ancestry are likely to weigh more than those of white ancestry leading black individuals to face discrimination if weight is a factor in wellness programs.[3] Since access to healthy foods is often limited in poverty stricken and urban areas,[4] areas often called food deserts, those with lower income will also be harmed by this using biometrics related to body size, weight, or proportion as a measure.

Using such biometrics as a proxy for health is not only inaccurate, it denies the reality of normal human diversity. Even if everyone ate well and exercised regularly, there will always be some proportion of the population that occupies higher weights; scientists have proven time and again that genetics play a significantly larger role in body size than habits.[5] Wellness programs that define such people as undesirable and unhealthy employees effectively consign an entire population to second-class status.

Therefore we support guidance that fulfills the ACA's intent, ensuring that workplace wellness programs do no harm. Basic principles of inclusivity, voluntary participation, accessibility for widely diverse levels of ability, and privacy protections, must be followed. While there is evidence that external incentives temporarily lead to behavior change, the development of intrinsic motivation is the only evidence-based model of sustained behavior change.[6] Writing in the New England Journal of Medicine in 2011, a group of behavioral economists headed by Dr. Kevin Volpp put it this way:

> 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 insurance data that have convincingly demonstrated such effects.[7]

The current evidence base for workplace wellness programs is primitive and relies on mostly short-term outcomes of less than one year. Epidemiologists have learned hard lessons about using such "snapshots" as outcome variables, because so many interventions, especially around diet and weight, prove to boomerang in the longer term and cause worse problems than no intervention.[8] The weight cycling literature cautions us to question the pursuit of weight loss (as opposed to the pursuit of sustainable health practices whether weight changes or not). The actual long term outcomes for the vast majority of people who try to change their body size leave people heavier, less healthy,[9] less in sync with their body's cues,[10] and more disordered in their eating than people who do not try to change their weight,[11] regardless of baseline body weight.[12]

In addition to being discriminatory and ineffective, workplace wellness programs can harm individuals who struggle with eating disorders. Eating disorder specialist Dr. Debora Burgard explains, "I am dismayed at the way many of my patients are exposed to workplace environments that amplify the already-intense weight focus of our culture. These kinds of workplace environments are toxic for almost everyone, but especially for people who have a history of being stigmatized for their weight and for people whose esteem is connected to their body size and appearance. The rates of disordered eating in the general population are quite high; many workers are being asked to participate in commercial weight loss programs that have a dismal track record for changing weight, and can result in disconnection with internal hunger/satiety cues."

Using biometrics related to body size, weight, or proportion as a proxy for health status - and compulsory participation in wellness programs - is wasteful and discriminatory in many ways. It turns out that using weight as a sign of ill health mislabels 51% of the healthy people unhealthy.[13] Additionally, such discriminatory practices actually cause stress to the affected individuals making their health worse in the end.[14]

Wellness programs should be open to people regardless of health status. They should be voluntary and make health practices more accessible to all. They should offer intrinsic rewards, like playfulness, stress relief, and skill building. If we want people to develop and maintain health-enhancing behaviors, we should be designing programs that are fun, programs that build skills, create social bonds, relieve stress, and increase opportunities for people to respond to individual bodily cues for hunger, satiety, play, and rest.

One model for such programs is Health at Every Size®. HAES programs are evidence-based, designed to foster people's innate capacity to know what they need.[15] Such programs take creative input from the community, listening carefully to the full range of needs and suggestions that come from people with varied physical capacities and preferences, and then build environments that create access and inclusion. This

approach is more like recess and less like the often dreaded treadmill test at the doctor's office.

To fulfill the intent of the ACA, and to comply with the anti-discrimination mandates of the ADA, GINA, ADEA, and Title VII, programs must be extremely careful - access to "desirable" biological markers is not equally available to each person. Genetics, life history, SES, exposure to discrimination, housing, educational and financial resources, and access to medical care are not distributed fairly. These unequal resources amplify inequalities based on race, age, gender, marital status, disability, sexual orientation, and national origin. To further reinforce the structural inequalities of our society by using "desirable" markers as a proxy for worth is to do further harm and can in no way be justified as a health intervention.

The intent of the ACA is greater access to healthcare, not greater access to private medical information for corporations. The intent of the ACA is to reduce discrimination, not to reinforce existing structural privileges that support the health of some groups and create barriers to health for other groups. The intent of the ACA is to end discrimination based on preexisting conditions, so discriminatory workplace wellness programs that create an ongoing preferential treatment based on health status must be avoided. The intent of the ACA's provision for workplace wellness programs is to multiply environments that support health, not to create a new reason for employers to discriminate against people who are not already in perfect health and create hostile work environments for them.

It would be a cruel development if the promise of inclusivity put forward in ACA ends up being broken when wellness programs effectively rebuild the same walls that ACA sought to tear down. Worse, such programs would justify and codify a disproportionate burden on already marginalized groups.

Thank you for your time and attention. We are happy to put you in touch with experts to answer any questions you may have.

Please view this linked document prepared by health expert Dr. Linda Bacon for supporting facts: http://www.lindabacon.org/welcome/wp-content/uploads/2013/05/Bacon_EEOC-comments-052113.pdf.

*Including but not limited to body size, shape, weight, proportions, or any ratio relating to such measurements.

Notes:

[1] Sherry L. Murphy, et al., *Deaths: Final Data for 2010*, 61 National Vital Statistics Reports (2013).

[2] U.S. Department of Labor, U.S. Bureau of Labor Statistics, *Highlights of Women's Earnings in 2011 (*October 2012), Report 1038, http://www.bls.gov/cps/cpswom2011.pdf

[3] Dale R Wagner and Vivian H Heyward, *Measures of body composition in blacks and whites: a comparative review* 71 Am. J. Clinal Nutrition 1392-1402 (June 2000), http://ajcn.nutrition.org/content/71/6/1392.long.

[4] L.M. Powella, et al., *Food store availability and neighborhood characteristics in the United States*, 44 Preventive Medicine 189-195 (2007).

[5] A.J. Stunkard, et al., *A twin study of human obesity* J. 256 Am. Med. Ass'n 51-54 (1986). A.J. Stunkard, et. al., *An adoption study: human obesity*. 314 N. Engl. J. Med. 193-198 (1986). J. Wardle, et al., *Evidence for a strong genetic influence on childhood adiposity despite the force of the obesogenic environment*. 87 Am. J. Clinical Nutrition 398–404 (2008).

[6] Linda Bacon, et al., *Size acceptance and intuitive eating improve health for obese, female chronic dieters*, 105 J. Am. Dietetic Ass'n 929-936 (June 2005).

[7] Kevin G. Volpp, et al., *Redesigning Employee Health Incentives — Lessons from Behavioral Economics*, 365 N. Engl. J. Med. 388-390 (August 4, 2011).

[8] Traci Mann, et al., *Medicare's Search For Effective Obesity Treatments: Diets Are Not The Answer*, 62 Am. Psyc. 220-233 (2007).

[9] A. J. Tomiyama, et al., *Low calorie dieting increases cortisol*, 72 Psychosomatic Med., 357-364 (2010).

M. L. Shiffman, et al., *Gallstone Formation after Rapid Weight Loss: A Prospective Study in Patients Undergoing Gastric Bypass Surgery for Treatment of Morbid Obesity* 86 Am. J. Gastroenterology 1000-1005 (2008).

[10] C. Herman, et al., *The self-regulation of eating: theoretical and practical problems*, Handbook of self-regulation: research, theory, and applications 492-508 (2004).

[11] B. A. Spear, *Does Dieting Increase the Risk for Obesity and Eating Disorders?* 106 J. Am. Dietetic Ass'n 523-525 (2006).

[12] Traci Mann, et al., *Medicare's Search For Effective Obesity Treatments: Diets Are Not The Answer*, 62 Am. Psyc. 220-233 (2007).

[13] Rachel P. Wildman, et al., *The Obese Without Cardiometabolic Risk Factor Clustering and the Normal Weight With Cardiometabolic Risk Factor Clustering: Prevalence and Correlates of 2 Phenotypes Among the US Population (NHANES 1999-2004)* 168 Arch Intern Med. 1617-1624 (2008).

[14] Peter Muennig, The body politic: the relationship between stigma and obesity-associated disease, 8 BMC Pub. Health 128 (2008).

[15] Bacon, L. and Aphramor, L. *Weight Science: Evaluating the Evidence for a Paradigm Shift,* 10 J. Nutrition (2011).