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Countering Workplace Wellness Bias through Wellness-Legal Partnerships

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Introduction

In the current United States economy, wellness is predominantly marketed to society's privileged individuals, catering to a mostly white and high-income clientele. When marginalized communities encounter wellness services, such as in the workplace, they are faced with an Implicitly biased industry. These biases include an emphasis on individual behavior change without considering social determinants of health (SDOH), cultural appropriation of wellness activities for capitalistic gain, use of biased health measures like Body-Mass Index (BMI) and constant images of and expectations of achieving a stereotypical healthy body. The legal community must wake up to these biases and advocate for more equitable wellness services. Wellness-Legal Partnerships (WLPs) are one type of tool that lawyers can use to address inequities baked into current workplace wellness programming. Specifically, lawyers can create WLPs through existing Employee Assistance Programs (EAPs) at Certified B Corporations to address SDOH. Part I of this paper explores the current state of the wellness industry and how the biases of emphasizing individual behavior, cultural appropriation of wellness activities, use of BMI and broadcasting the stereotypical healthy body image adversely impact historically marginalized people. Part II examines workplace wellness programs and how those programs not only incorporate the biases prevalent in the wider wellness industry, but how workplace wellness laws under the Affordable Care Act (ACA) and the Americans with Disabilities Act (ADA) arguably encourage them to do so. Part III explores the history and legal framework of EAPs and their current use by employers and employees. Part III introduces the concept of WLPs by describing the WLP role model, Medical-Legal Partnerships (MLPs) and how WLPs can adopt many of the same MLP concepts and apply them to workplace wellness programs. Then, this Part offers a roadmap on how to start implementing WLPs in workplace wellness programs to demonstrate how these partnerships can not only address SDOH faced by employees, but also offer broader advocacy services by lawyers dedicated to addressing the multiple biases that currently exist in wellness services.

I. The Implicit Bias in the Wellness Industry

In 1959 Halbert L. Dunn offered one of the first definitions of wellness, defining the term as "maximization of health through an integrated method of functioning, keeping in consideration *an individual's environment*."[1] Dunn's recognition of the importance of individual's environment to their overall wellbeing has been lost over the years. As discussed in this article, the predominant view of wellness is on personal responsibility. Yet, reminders abound in medical literature that one's genetics, medical care and health behaviors contribute but a small percentage to one's health.[2] By far the

[1] Carrie Griffin Basas, What's Bad about Wellness? What the Disability Rights Perspective Offers about the Limitations of Wellness, J. of Health Politics, Policy and Law, Vol. 39, No. 5, at 1050 (Oct. 2014) (emphasis added).

[2] See e.g., Emily A. Benfer, Abbe R. Gluck, and Katherine L. Kraschel, Medical-Legal Partnership: Lessons from Five Diverse MLPs in New Haven, Connecticut, J. of Law Medicine and Ethics, Vol. 46, at

largest contributor are what have been termed the "Social Determinants of Health" or "SDOH," which are social and environmental factors such as income, access to healthcare, healthy food and housing, race, education, job stability and personal safety.[3] The wellness industry, starting with workplace wellness programs, must revive Dunn's more holistic definition of wellness and start addressing the SDOH and their impact on overall wellbeing. This paradigm shift for wellness to address SDOH is especially important for historically marginalized people. The current wellness industry does not work for them. In fact, the current wellness industry is biased against those who are not white, affluent, thin, and physically able.

In contrast to Dunn's definition of wellness, for many people in the United States today, the term "wellness" spurs images of exercise, healthy diets, yoga, or a day at the spa. Closely related to these activities are images of a thin, able-bodied persons who are also often white, affluent, and female. That image of the model wellness consumer is not an accident. The tie between wellness marketing and thin, able-bodied individuals is meant to promote an aspiration of health that for most people is unattainable.[4] And the fact that the individuals are often white women traces back centuries to racial bias against Black bodies, a concept discussed more fully below.[5]

The economic hook for wellness industry marketing is preying upon emotional fears of never being good enough based on standards often set by the dominant, white culture.[6] These standards for what qualifies as being "well" demand personal responsibility, meeting certain health metrics, achieving a healthy-looking body, and engaging in culturally appropriated self-care activities driven by capitalistic motives. Each of these aspects of the current wellness climate discriminate against, disrespect and disregard historically marginalized people, such as racial minorities and those with disabilities. After giving a brief overview of the current wellness industry in the United States, this

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602 (2018) (stating only 25% of individual health is determined by genetics, medical care, and health behaviors, while 75% of health is determined by social and environmental factors such as income, access to healthcare, healthy food and housing, education, job stability and personal safety); Steven H. Woolf, Necessary but Not Sufficient: Why Health Care Alone Cannot improve Population Health and Reduce Health Inequities, Annals of Family Medicine, Vol. 17, at 196 (2019) (citing studies that conclude health care accounts for less than 20% in premature mortality and that the major influences on health lie outside the clinic); Ben Schwan, Responsibility Amid the Social Determinants of Health, Bioethics, Vol. 36, at 8 (2020) (stating that one's neighborhood, level of education, income, race, employment status, and more are correlated with a variety of positive and negative health outcomes).

[3] Id.

[4] Rina Raphael, The Gospel of Wellness, at 280-283 (Holt Publishing 2022) (noting that the wellness industry coalesces around emotion and consumerism and thin, wealthy, and attractive represents the appearance of health); see also page 273 (noting that wellness ads tell us health can be attained, maintained, and elevated, but every time you reach a milestone, the goalpost moves further away).

[5] Sabrina Strings, Fearing the Black Body, NYU Press, eBook at 6 (2019).

[6] Id. at 273 (Unattainability keeps you chasing wellness, which keeps you always consuming); see also Dalia Kinsey, Decolonizing Wellness, at 52-53 (Ben BellaBooks 2022) (stating that the dominant, white culture in the United States uses fatness as a scapegoat to eliminate culpability for people in positions of power to uphold systems of oppression and that the obsessive focus on policing the size of Black and brown bodies in lieu of calling the dominant culture to task for terrorizing, suppressing, and bullying folks of color is reflective of the misguided assumption that white culture is ideal).

article will address each of these aspects of wellness and how they adversely impact historically marginalized people.

A. A Snapshot of the Current Wellness Market

According to McKinsey & Company, most consumers define wellness in six dimensions:

1. **Health**: over-the-counter medicine, vitamins, and personal hygiene
2. **Fitness**: fitness clubs, studios, at-home fitness equipment, and fitness wearables
3. **Nutrition**: diet programs, subscription food services, nutrition apps, and juice cleanses
4. **Appearance**: skin care, dermo-cosmetics, hair care, and salon services
5. **Mindfulness**: counseling or therapy, meditation studios, and mindfulness apps
6. **Sleep**: sleep supplements, app-enabled sleep trackers, and other sleep-enhancing products.[7]

One underlying theme among these dimensions of wellness is that they relate to a choice: a choice to engage in self-care, usually not covered by any subsidized health insurance. So, people in the broader community who want to engage in self-care must pay out-of-pocket for most wellness products and services. And consumers spend a lot of their own money on wellness products and services. According to McKinsey & Company, consumers in the United States spend more than $450 billion on wellness products and services, and that spending is growing at more than five percent annually.[8] Moreover, according to that same McKinsey & Company report, in 2022 around half of all U.S. consumers report wellness as a top priority in their daily lives, a rise from just 42 percent two years earlier.[9]

The ability to engage in and benefit from wellness activities like exercise and eating a healthy diet is not equally distributed among racial and physical ability lines. Indeed, the biggest group of wellness service providers and consumers are Caucasian, physically able consumers, particularly white women. For example, according to the Commission on Dietetic Registration, in 2020, 92 percent of all registered dietitians were female, 80 percent were white, while just 3 percent were Black, 6 percent were Hispanic or Latinx, and 5 percent were Asian.[10] Even McKinsey has exposed the lack of attention to Black

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[7] Shaun Callaghan, et al., Still Feeling Good: The US wellness market continues to boom, McKinsey & Company, at 2 (September 2022), available at https://www.mckinsey.com/industries/consumer-packaged-goods/our-insights/still-feeling-good-the-us-wellness-market-continues-to-boom#/ (last visited November 7, 2023).

[8] Shaun Callaghan, et al., Still Feeling Good: The US wellness market continues to boom, McKinsey & Company, at 2 (September 2022), available at https://www.mckinsey.com/industries/consumer-packaged-goods/our-insights/still-feeling-good-the-us-wellness-market-continues-to-boom#/ (last visited November 7, 2023).

[9] Id.

[10] Commission on Dietetic Registration, Needs Satisfaction Survey (2020), available at https://www.cdrnet.org/academy-commission-on-dietetic-registration-demographics (last visited October 25, 2023).

consumers by the wellness industry, finding that 47 to 55 percent of surveyed Black consumers said they desired more wellness products and services to meet their specific needs.[11]

Similar demographics exist for yoga practice, another popular wellness activity. Research shows that yoga practice has a number of health benefits, and involves physical poses, breathwork, concentration, meditation, ethical tenets, spirituality, inward attention and self-knowledge.[12] The data around yoga practice also shows that the typical yoga practitioner is female, from upper socioeconomic classes, educated, middle-aged and White.[13] Frequent yoga practitioners are also more likely to eat a healthy diet and have a lower Body Mass Index (BMI) compared to non-practitioners.[14] The reasons for the strong association between wellness and White and ableist privilege include the current emphasis by the wellness industry on individual behavior, cultural appropriation and use of and reliance on historically biased body images and measures like BMI.

B. The Wellness Industry's Emphasis on Individual Behavior

The broad appeal of the wellness industry is the sense of control wellness practices provide.[15] "Woven throughout [wellness] lies the message that you can manipulate what is unruly, subpar, or standing in the way of progress. Buy it, use it, think it – and you're back in the driver's seat."[16] Assuming personal responsibility for one's health fits squarely within American culture, which tends to revere "autonomy over equality."[17] As a result, much of the wellness industry's economic engine is predicated on inspiring people to improve their own health.[18] It assumes not only that people can change, but that people have the resources to invest in themselves in order to attain that ideal state of wellbeing. For many people, that assumption is at best unhelpful and at worst, discriminatory.

Author Dalia Kinsey sums up one rationale behind the individual behavior focus as follows:

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[11] Shaun Callaghan, et al., Still Feeling Good: The US wellness market continues to boom, McKinsey & Company, at 9-10 (September 2022), available at https://www.mckinsey.com/industries/consumer-packaged-goods/our-insights/still-feeling-good-the-us-wellness-market-continues-to-boom#/ (last visited November 7, 2023). "In comparison, 35 to 39 percent of Asian consumers and 30 to 35 percent of White consumers said the same." Id.
[12] Crystal L. Park, et al., Who Practices Yoga? A Systematic Review of Demographic, Health-Related, and Psychosocial Factors Associated with Yoga Practice, J. Behav. Med., Vol. 38, at 460 (2015).
[13] Id. at 463.
[14] Id. at 466-67.
[15] Rina Raphael, The Gospel of Wellness, at 256-57 (Holt Publishing 2022) (noting that the perception of control reduces anxiety, fear and stress levels which contribute to overall mental health, but perceiving control also encourages us to buy things we don't necessarily need).
[16] Id.
[17] Roberts and Fowler, at 116.
[18] Raphael at 266 (observing that rebranding a medical condition or procedure to "self-care," such as infertility treatments, can feel empowering and destigmatizing) and at 272 ("The allure of control is communicated throughout wellness.").

> Blaming the consumer or the individual for their habits is suspiciously convenient. It allows members of the dominant culture in positions of power to continue to believe that their norms are superior to those of minority cultures. And it enables them to occupy the ever-popular white savior position, where they're helping to civilize people of color for their own good. And oh, aren't we lucky that they're ready to help us?[19]

Kinsey continues by highlighting the $70 billion diet and weight loss industry in the United States exists to generate income, not improve overall wellbeing.[20] Dieting distracts individuals from meaningful things, such as addressing the history behind dieting as a form of oppression.[21] Kinsey aptly asks why Americans, especially those from marginalized communities, spend so much money supporting companies that push for some beauty standard that is not necessarily healthy at all, either physically or emotionally?[22]

Rina Raphael attempts to answer that question by describing wellness as a luxury item and marketed as an aspirational goal. People want luxury items and lifestyles, even if they cannot afford it and even though the wellness market spurs ageism, ableism, and elitism. [23]

According to Kanoelani Patterson, a fat-positive activist and powerlifter, diet culture is rooted in racism. [24] She states that the "nutrition advice given is often centered in whiteness without acknowledging the ties of capitalism, racism, and white supremacy, which all lead to a lack of accessibility as well as food deserts."[25] "Food deserts" are areas where access to grocery stores with healthy foods like fresh fruits, vegetables, lean meat, whole grains are limited or nonexistent.[26] According to the Southern Poverty Law Center, communities of color tend to face the most difficulty accessing grocery stores, with only eight percent of Black people in the United States living in a census tract (a region with an average population of 4,000) with a grocery store, compared to 31 percent of white people.[27] Instead, residents of food deserts may rely more on fast food

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[19] Dalia Kinsey, Decolonizing Wellness, at 53-54 (Ben Bella Books 2022).
[20] Id. at 55.
[21] Id at. 46
[22] Id. at 46-61 (noting that wellbeing is multi-faceted, that there is no scientifically proven intervention for significant long-term weight loss and that weight gain is the proven long-term result of dieting. "There is far more evidence to indicate that dieting can hurt you than there is evidence suggesting that dieting can help you" and therefore recommending dieting as a health-promoting behavior is unconscionable.).
[23] Rina Raphael, The Gospel of Wellness, at 284-285 (Henry Holt Publishing 2022).
[24] Chrissy King, Racism Needs to be Part of the Conversation about Dismantling Diet Culture, Shape Magazine (Feb. 9, 2021), available at https://www.shape.com/lifestyle/mind-and-body/racism-diet-culture (last visited October 25, 2023) (stating that "White culture tends to focus more on the individual, while BIPOC culture is rooted more in collectivism and community.").
[25] Chrissy King, Racism Needs to be Part of the Conversation about Dismantling Diet Culture, Shape Magazine (Feb. 9, 2021), available at https://www.shape.com/lifestyle/mind-and-body/racism-diet-culture (last visited October 25, 2023).
[26] Id.
[27] Food Desert Statistics, Teaching Tolerance Fact Sheet, Southern Poverty Law Center, available at https://www.learningforjustice.org/sites/default/files/general/desert%20stats.pdf (last visited October 25, 2023); see also Sarah Treuhaft and Allison Karpyn, The Grocery Gap: Who Has Access to Healthy Food

restaurants and convenience stores, which if such stores carry healthy foods, those foods often cost more than they would at a grocery store.[28] This heavy concentration of fast food restaurants and convenience stores is known as "food swamps."[29] Researchers note that it is no accident that marginalized Black, Indigenous, and People of Color (BIPOC) communities are disproportionately located in food swamps; encouraging minorities to consume more ultra-processed food relates back to redlining, de facto segregation, white flight and corporate entities that profit based on junk food sales.[30]

The tendency of wellness programs to overemphasize individual accountability while failing to account for SDOH is how the wellness industry exacerbates health inequity.[31] As Raphael observes, "[w]ealth and wellness are near synonymous terms these days, morphing the idea of health as a necessity into one of indulgence."[32] The statistics of who benefits from wellness offerings bear this out. A 2018 study found that seventy-five percent of wealthy individuals exercise on most days compared to only twenty-five percent of lower-income populations.[33] And that gap will continue to widen until the wellness industry steps back and looks beyond individual behavior and lifestyle choices. Equally significant, if not more so, to one's health status are socioeconomic factors and structural barriers, which can limit one's ability to make healthy choices.[34] As one author puts it, throwing wellness programs that merely make resources available to lose weight or stop smoking are merely addressing the symptoms and not the cause of poor health.[35] Assuming that everyone is capable of adopting healthy behaviors if they just "try" is unfair and distracts wellness programs from the environmental factors that truly impact health choices.[36]

These more "upstream" environmental factors, or SDOH, are things like living in food deserts or food swamps, unsafe neighborhoods, educational level, income, race, employment status, domestic trauma, social isolation, residential segregation, and

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and Why it Matters, PolicyLink and The Food Trust (2010), available at file:///Users/barbarazabawa/Downloads/FINALGroceryGap.pdf (last visited October 25, 2023).

[28] Id.

[29] D.G. Aaron and F.C. Stanford, *Is Obesity a Manifestation of Systemic Racism? A Ten-Point Strategy for Study and Intervention*, Journal of Internal Medicine, Vol. 290, at 417 (2021) (defining food swamps as areas of dense with sellers of processed and fast food).

[30] Id.

[31] Carrie Griffin Basas, What's Bad about Wellness, at 1052 (stating that the wellness imperative to push for individual responsibility shifts attention from societal barriers to health, discrimination based on perceived unhealthy states, and inequitable resource allocation to personal improvement and paternalistic intervention).

[32] Raphael, at 277.

[33] Id. at 277 (citing Tom Corley, "Author Who Studies Millionaires: 240 Minutes a Day Separates the Rich from Everyone Else," CNBC, June 22, 2018).

[34] Roberts and Fowler, at 116.

[35] Id. at 116-17.

[36] Id. at 120-21; see also Laura D. Hermer, The Means and Ends of Wellness Programs, J. of Health Care Law & Policy, Vol. 23, at 229 (2021) (stating that the focus on health improvement efforts focuses attention away from the larger causes of health problems, while blaming individuals for matters that are not completely within their control).

structural racism.[37] Indeed, studies have shown that medical care accounts for only 10 percent to 20 percent of variation in premature mortality.[38] Other factors, like health behaviors, the physical and social environment, socioeconomic status, and public policy, also significantly influence health, and "socioeconomic status may be the greatest influence on health."[39] "People can only make the choices they have: they cannot eat well if they live in a food desert, they cannot exercise or play outside if the built environment is unsafe."[40] These upstream social determinants play a more significant role in health-related decisions than the more "downstream" education and behavior change approaches that make up most current wellness programming.[41] Therefore, a natural criticism of the wellness industry's myopic focus on individual responsibility is that it obscures the extent to which health outcomes are influenced by larger social and environmental factors that often render people not responsible for their health.[42]

C. The Wellness Industry's Cultural Appropriation of Wellness Activities

The world of wellness consists of many alternative healing methods, such as reiki, ayurveda, yoga, and meditation to name a few. But in the United States, practicing these healing methods can infringe on the broadly defined scope of practice of Western medicine, which most state medical practice laws define as including everything that by common understanding is a "healing art."[43] Organized medicine has worked diligently to either expand medicine's authority over alternative practices through either limited licensure or eliminating alternative practices by labeling alternative medicine practitioners as "cultists," "quacks," or "charlatans" who are uneducated and incompetent to treat human ailments.[44]

One interpretation of Western medicine's rejection of these alternative practices as "quackery" is a dominant culture dismissing traditional healing modalities of people of color.[45] This dismissal by the medical establishment of alternative practices disconnects people of color from their healing traditions, while at the same time creates distrust in Western medicine.[46] This dynamic exacerbates unequal access to Western medical care.[47]

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[37] Steven H. Wolf, Necessary But Not Sufficient: Why Health Care Alone Cannot Improve Population Health and Reduce Health Inequities, 17 Annals of Family Medicine at 196 (May/June 2019); Ben Schwan, Responsibility Amid the Social Determinants of Health, 35 Bioethics, at 8 (2021).
[38] Id.
[39] Id.
[40] Id; see also Roberts and Fowler, at 118 ("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.").
[41] Roberts and Fowler, at 118.
[42] Schwan, at 8.
[43] Carl F. Ameringer, State Medical Boards and the Politics of Public Protection, at 26 (Johns Hopkins U. Press 1999).
[44] Id. at 16-26.
[45] Dalia Kinsey, Decolonizing Wellness, at 13 (Ben Bella Books 2022).
[46] Id.
[47] Id.

The dismissal by Western medicine of traditional healing modalities of people of color is a symptom of a larger problem: the destruction of cultures that the West colonized so that it could be the authority and no one else could compete.[48] "Colonial thought relied upon destroying or extracting knowledge from the cultures it colonized."[49]

But not everyone rejects the traditional healing methods of people of color. Indeed, as noted earlier, yoga is quite popular among white women in the United States. The "whitewashing" of wellness is another way wellness is racially biased; the white population in the United States has culturally appropriated many wellness traditions and in the process, undermined the meaning of these traditions for the people who invented them. As a result, people of color may feel disconnected to the whitewashed version of the wellness services and activities offered by members of the white population.

A teachable example of cultural appropriation is "mindfulness meditation," which has become an extremely popular trend in the wellness movement.[50] Often combined with yoga, employers offer employees mindfulness meditation as part of their wellness programs to "improve workplace functioning and support optimal performance of employees."[51] But using mindfulness meditation to improve one's performance at work dishonors the origins of the practice. As Fahira Roisin reveals in her book *Who is Wellness For?,* "[m]editation is a perfect entry point into looking at how something becomes taken, diluted, and then decontextualized and sold back to rich white people at a steep price."[52] According to Roisin, meditation was first seen in the Vedas, a large body of religious texts, around 1500 BCE, and is seen as a spiritual exercise, as well as a religious practice, in both Hinduism and Buddhism.[53] In India, Buddhism introduced meditative practice to all people, regardless of caste.[54] "The cultural and spiritual genesis of meditation grew out of inquiry about the state of consciousness and what lay behind the guise of what we do and do not know – but also who [we] are and how we came to be."[55] The origins of meditation, then, are closely intertwined with the concepts of Buddhism, which is to treat all people, regardless of race or caste, as one family.[56] Meditation helps unify the practitioner's mind, body and spirit to understand how to be

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[48] Fariha Roisin, Who is Wellness For? An Examination of Wellness Culture and Who it Leaves Behind, at 59 (Harper Collins 2022) ("The West didn't position itself as an authority by accident, it did so by destroying the playing field to ensure nobody else could compete. They wanted to present themselves as the only purveyors of esteemed knowledge, and what this required was murdering half of the world. Which they did.").
[49] Id.
[50] Laura G. Hilton, et al., Mindfulness Meditation for Workplace Wellness: An Evidence Map, Work, Vol. 63, at 205-06 (2019) (noting the increased use of the complementary integrative health practice called "mindfulness meditation" in occupational health).
[51] Id. at 206 (noting that prominent companies such as Google, Aetna, and General Mills offer employees mindfulness training to improve their effectiveness and thirteen percent of US workers report engaging in mindfulness-enhancing practices).
[52] Fahira Roisin, Who is Wellness For?, at 40.
[53] Id.
[54] Id. at 40-42.
[55] Id. at 42.
[56] Id. at 42-43.

human.[57] Western culture has co-opted Indian spiritual thought for capital gain. "Meditation apps monetize mindfulness; Headspace's revenue is estimated at $50m a year and the company is valued at $250m."[58] In contrast to the original purpose of meditation as used in Eastern religious traditions, "McMindfulness promotes self-aggrandizement; its therapeutic function is to comfort, numb, adjust and accommodate the self within a neoliberal, corporatized, militarized, individualistic society based on private gain."[59]

Kinsey points out that "there are limited to zero resources giving voice to the experiences and issues around food, body image, and self-acceptance faced by marginalized groups and communities from the perspective of an actual member of those groups."[60] Hijacking wellness concepts and then acting as the authoritative voice about what it means to be well, look well, eat well, is a form of discrimination because it fails to recognize cultural and societal differences that play a significant role in wellbeing.

Raphael's book recounts stories of Hispanic women in Miami exclaiming that yoga is for "white people, not for us" until a bilingual yoga teacher established a bilingual yoga teacher training course.[61] She also highlights the Black Yoga Teachers Alliance, a nonprofit and professional membership organization that tries to broaden access to wellness activities to underrepresented groups.[62] But these efforts are not mainstream. Just like conventional health care fails to offer culturally competent services to racial minorities that then creates distrust and exclusion in health services,[63] the wellness industry also fails miserably at creating inclusive environments for historically marginalized people. The Western world's idea of wellness is largely exclusive and caters to the dominant, white culture to the point that even wellness metrics like body mass index exclude people of color.

D. The Wellness (and Health Care) Industry's Use of a Historically Biased Measure: Body Mass Index (BMI)

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[57] Id.
[58] Id. at 46 (citing David Forbes, How Capitalism Captured the Mindfulness Industry, Guardian (April 16, 2019)). Headspace is a mindfulness app that one purchases for a monthly subscription fee that claims to help the consumer stress less, sleep soundly and relax more. See Headspace Website at https://www.headspace.com/newyear?utm_source=google&utm_medium=search&utm_campaign=HS_Headspace_Brand-Exact_Search_US-NorAm_Google_NA&utm_content=&utm_term=headspace%20app&gad_source=1&gclid=Cj0KCQiAhc-sBhCEARIsAOVwHuRa_rR7tFn2CRi5Xg5jpXlRgdYlQQfXG3d_aAcPvFGvlV5kX_HlrDQaAl1IEALw_wcB (last visited January 2, 2024).
[59] Id. at 47.
[60] Dalia Kinsey, Decolonizing Wellness, at 13 (Ben Bella Books 2022).
[61] Rina Raphael, The Gospel of Wellness, at 289-90.
[62] Id.
[63] Report, Leslie Read, Heather Nelson and Leslie Korenda, Rebuilding Trust in Health Care, Deloitte Insights, at 3 (2021), available at https://www2.deloitte.com/us/en/insights/industry/health-care/trust-in-health-care-system.html (last visited December 20, 2023).

According to the American Medical Association (AMA), Body Mass Index (BMI) measures whether someone is overweight or obese.[64] BMI is the ratio of weight to height, calculated by dividing the square of one's height (in inches, for example) into one's weight (in pounds, for example) and then multiplying by 703. So, an adult female weighing 150 pounds and who is five feet, eight inches (i.e., 68 inches) tall has a BMI of 22.8. [65] According to the AMA, BMI levels between 20 and 24.9 are "normal," BMI levels above 25 indicate a person is overweight and has an increased risk of morbidity and mortality, and BMI levels of 30 or more indicate obesity.[66]

These cut-off points for a "healthy" BMI and an "unhealthy" one date back almost 200 years. In 1835, Adolphe Quetelet, a Belgian astronomer and mathematician, recorded measurements of the human body in his quest for characterizing the "normal man."[67] His measurements were based on white men from Western Europe. Notably, Adolphe Quetlet's work with height and weight indices had a role in the origins of eugenics.[68]

Metropolitan Life Insurance Company used Quetlet's indices in the 1940s to establish how weight might play a role in morbidity and mortality.[69] "The company used the BMI formula and several decades of data from mostly White male policyholders to create actuarial tables."[70] In 1972, Quetelet's indices were renamed "BMI" by American physiologist Ancel Keys and adopted by the World Health Organization to classify body sizes as underweight, normal or average, overweight and obese.[71]

The BMI classifications still exist today, even though the one-size-fits all measure is based on a mostly Caucasian, mostly male population from decades, if not centuries, ago. As a result, BMI does not account for differences in body type because of race, ethnicity, or gender. In fact, researchers recently have proposed adjusting BMI cut offs to reflect racial and ethnic variation in body composition.[72] According to Fatima Cody Stanford, an

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[64] AMA Report 07 of the Council on Science and Public Health, presented at the AMA Annual Meeting in Chicago, IL, June 9-13, 2023, available at https://www.ama-assn.org/system/files/a23-handbook-refcom-d.pdf#page=65 (last visited October 19, 2023) (hereinafter AMA Report).
[65] Id. at 2.
[66] Id. at 4-5.
[67] McKenzie Prillaman, Beyond BMI: How to Redefine Obesity, Nature, Vol. 622, at 232 (Oct. 12, 2023), available at https://www.nature.com/articles/d41586-023-03143-x.pdf (last visited October 19, 2023); see also Garabed Eknoyan, Adolphe Quetelet (1796-1874) – the average man and indices of obesity, Nephrology Dialysis Transplantation, Vol 23, at 47-51 (2008); Carly Stern, Why BMI is a flawed health standard, especially for people of color, The Washington Post (May 5, 2021).
[68] McKenzie Prillaman, Beyond BMI: How to Redefine Obesity, Nature, Vol. 622, at 232 (Oct. 12, 2023), available at https://www.nature.com/articles/d41586-023-03143-x.pdf (last visited October 19, 2023).
[69] Carly Stern, Why BMI is a flawed health standard, especially for people of color, The Washington Post (May 5, 2021).
[70] Id.; see also AMA Report at 3.
[71] McKenzie Prillaman, Beyond BMI: How to Redefine Obesity, Nature, Vol. 622, at 232 (Oct. 12, 2023), available at https://www.nature.com/articles/d41586-023-03143-x.pdf (last visited October 19, 2023); AMA Report at 4.
[72] Fatima Cody Stanford, MD, MPH, MA, Letters to the Editor: Race, Ethnicity, Sex, and Obesity: Is it Time to Personalize the Scale?, Mayo Clin. Proc., Vol. 94(2), at 362-369 (Feb. 2019), available at

obesity medicine physician scientist at Massachusetts General Hospital and Harvard Medical School, when one defines obesity as the correlation with the presence of metabolic risk factors like hypertension, dyslipidemia, and diabetes, the BMI cutoffs would change for specific race/ethnicity and sex subgroups.[73] Notably, a BMI tailored to sex and race would create a higher cut off point for black and Hispanic women when compared to white women (31, 29, and 27, respectively), the same cut off point for Hispanic women and white men (29), and a lower cut off point for black and Hispanic men when compared to white men (28, 28 and 29, respectively).[74] If the point of measuring BMI is to assess whether someone's weight puts them at a higher risk of costly disease, then using a BMI tailored to one's gender and racial/ethnic background makes sense.

Although the current one-size-fits all BMI does correlate with risk of death and disease at a population level, it is an inadequate measure at the individual level.[75] Indeed, one study found that about 30% of participants with obesity had good cardiometabolic health (e.g., healthy blood pressure and cholesterol levels) while about 30% of people in a healthy BMI range had poor cardiometabolic health.[76] Thus, BMI is a poor measure of an individual's health status. "Many poor health outcomes that are typically blamed on obesity could also be explained in part by the fact that people in larger bodies are denied equal access to health care." Higher BMI could also be a symptom of lack of resources, such as time and money, for self-care.[77] Adding weight stigma to an already stressful life is the opposite of health promoting activity.[78]

Yet, despite the evidence that BMI is useless at the individual level, the wellness and health care industries continue to rely on it to allocate scarce health resources or determine eligibility for insurance or cost of insurance premiums.[79] As discussed further below, many workplace wellness programs tie financial incentives to employees meeting a "healthy" BMI. Given the racial bias of BMI, such incentives will disproportionately punish racial minorities, particularly Black women. The American Medical Association

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https://www.mayoclinicproceedings.org/article/S0025-6196(18)30807-3/pdf (last visited October 19, 2023).

[73] Id; Carly Stern, Why BMI is a flawed health standard, especially for people of color, The Washington Post (May 5, 2021).

[74] Fatima Cody Stanford, MD, MPH, MA, Letters to the Editor: Race, Ethnicity, Sex, and Obesity: Is it Time to Personalize the Scale?, Mayo Clin. Proc., Vol. 94(2), at 362-369 (Feb. 2019), available at https://www.mayoclinicproceedings.org/article/S0025-6196(18)30807-3/pdf (last visited October 19, 2023).

[75] McKenzie Prillaman, Beyond BMI: How to Redefine Obesity, Nature, Vol. 622, at 232 (Oct. 12, 2023), available at https://www.nature.com/articles/d41586-023-03143-x.pdf (last visited October 19, 2023).

[76] Id. at 233.

[77] Dalia Kinsey, Decolonizing Wellness, at 62 (Ben Bella Books 2022).

[78] Id. at 63.

[79] Sabrina Strings, Fearing the Black Body: The Racial Origins of Fat Phobia, Electronic Edition, at 188-89 (New York Univ. Press 2019) (noting that medico-actuarial standards of weight and health in the early twentieth century were used to determine eligibility for insurance coverage and who physicians wanted to take on a as a patient).

(AMA) has just recently proclaimed that the medical community should no longer use BMI as a measure of obesity because of its racist history.[80]

Not only is continued use of BMI ineffective from a medical evidence standpoint, but it also leads to body shaming and body policing. Kinsey points out that even nutritionists working for public health departments weighed each client at every visit and gently reminded them to strive for low BMIs. Kinsey criticizes the disconnect the nutritionists had from their clientele. Instead of trying to understand the stressful lives of the Black and brown people the public health department served, the mostly white nutritionists merely added food preoccupation to "the already-long list of things weighing on our clients' minds."[81] As noted previously, low BMIs do not necessarily equate with good health, and pushing people to achieve a low BMI is particularly rooted in discriminatory treatment of Black women.

E. The Implicit Bias in the Stereotypical Healthy Body

Closely related to the implicit bias in BMI is what is typically viewed as a healthy body image. Thinness is at the heart of the ideal healthy body image. Wrapped up in the thin body image is diet culture, which has its origins in Eurocentric beauty aesthetics of the Seventeenth Century.[82] According to Sabrina Strings, author of *Fearing the Black Body: The Racial Origins of Fat Phobia*, the transatlantic slave trade and the spread of Protestantism played a significant role in the Western world's obsession with thinness and phobia about fatness.[83] "Racial scientific rhetoric about slavery linked fatness to 'greedy' Africans. And religious discourse suggested that overeating was ungodly." Only once the fatness had been stigmatized as both black and sinful did the medical community declare fatness as a public health issue.[84] According to Strings, this latent response from the medical community is evidence that society's distaste for fatness and preference for thinness is not about health at all, but about creating race, sex and class hierarchies.[85] Indeed, medicine stepped in as religion played a less significant role in American life in the twentieth century.[86] The medical community began to tell patients, particularly elite white women, "how to live" – "that is, how, what, when, and how much to eat."[87] The medical community rarely included racial/ethnic minorities in medical analyses; instead,

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[80] Press Release, Sara Berg, AMA: Use of BMI Alone is an Imperfect Clinical Measure (June 14, 2023), available at https://www.ama-assn.org/delivering-care/public-health/ama-use-bmi-alone-imperfect-clinical-measure (last visited December 20, 2023) (stating that the AMA House of Delegates adopted a new policy recognizing the issues with using BMI as a measurement because of the historical harm of BMI, the use of BMI for racist exclusion, and BMI cutoffs are based primarily on data collected from previous generations of non-Hispanic white populations and does not consider a person's gender or ethnicity).
[81] Dalia Kinsey, Decolonizing Wellness, at 5 (Ben Bella Books 2022).
[82] Id. at 44; Fearing the Black Body.
[83] Sabrina Strings, Fearing the Black Body: The Racial Origins of Fat Phobia, Electronic Edition, at 6 (New York Univ. Press 2019).
[84] Id.
[85] Id.
[86] Id. at 194.
[87] Id.

to the extent that the medical literature described implicit racial deficiency, it resulted from sentiment and impression and not scientific findings.[88]

The historical discourse of fatness as "coarse," "immoral," and "black" worked to "denigrate black women, and it concomitantly became the impetus for the promulgation of slender figures as the proper form of embodiment for elite white Christian women."[89] Thus, images of fat black women served two purposes: to degrade black women and to encourage white women to strive for slenderness as the proper form of embodiment for elite white Christian women.[90] As the statistics of wellness participation discussed earlier demonstrate, that racial and gender demographic slant continues today.

Similarly, Kinsey observes that dieting is a game that was originally set up to oppress people of color and femme-identifying people.[91] Dieting relates to an ideal beauty standard that traces back to the slave trade as a way to encourage the white perpetrators and beneficiaries of human trafficking to distinguish themselves as "morally superior" from the "supposedly inferior enslaved people."[92] Creating these distinctions helped justify their crimes against humanity.[93] Thus, "[r]ace science was used to identify traits of inferior and superior humans, leading to the bogus conclusions that Black people were lazy by nature and suffered from poor impulse control in relation to sexual pleasure and food, while morally superior people are able to resist carnal urges and maintain bodies that fit the thin ideal."[94]

Based on this historical background, and the fact that the human body functions best when it is allowed to self-regulate, Kinsey asks whether obtaining the thin ideal through dieting and exercise is something we really want to do, or something that we feel compelled to do because of norms set by the dominant culture?[95] In effect, Kinsey argues, dieting and wellness culture is just a distraction from more critical issues, like oppression of historically marginalized people.[96] "Blaming the consumer or the individual for their habits is suspiciously convenient. It allows members of the dominant culture in positions of power to continue to believe that their norms are superior to those of minority cultures" and enables them to occupy the "ever-popular white savior position, where they're helping to civilize people of color for their own good."[97] Furthermore, pathologizing obesity rather than accepting body diversity is economically advantageous, generating approximately $70 billion in the United States alone.[98]

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[88] Id. at 195 (For example, in reference to Jewish individuals, Dr. Elliott Joslin wrote in a 1921 article published in the Journal of the American Medical Association: "The Jew, in my opinion, is not prone to diabetes because he is a Jew, but rather because he is fat. Jews are fat; though shameful to relate.").
[89] Id.
[90] Id. at 211.
[91] Dalia Kinsey, Decolonizing Wellness, at 46 (Ben Bella Books 2022).; Fearing the Black Body.
[92] Id. at 45.
[93] Id.
[94] Id.
[95] Id. at 46-52.
[96] Id.
[97] Id. at 53-54.
[98] Id. at 55.

Each of the types of wellness bias discussed above - the emphasis on individual behavior, the cultural appropriation of wellness activities, the use of racially-biased measures like BMI and the stereotypical image the "ideal healthy body" – create a dark cloud over the aspirational and positive nature of wellness. These biases call into question the true purpose behind wellness programs and force us to ask whether wellness is even worth pursuing. Before tackling that latter question, it is important to examine how workplace wellness programs perpetuate wellness industry bias.

II. Workplace Wellness Programs Adopt Wellness Biases

A. Background on Workplace Wellness Programs

Because most Americans obtain health coverage through their employer, employers have a lot at stake in employee health.[99] In 2023, 53% of all employers offered some health benefits.[100] Health insurance accounts for 6.9 percent of total employee compensation[101] and employers anticipate a 7 percent rise in health care costs for 2024 compared to 2023.[102] Employers attribute the rise in medical plan costs for 2024 in large part to chronic health conditions.[103]

One way employers can presumably tackle employee health, especially chronic health conditions, is through workplace wellness programs.[104] Workplace wellness programs are "programs of health promotion and disease prevention" that encourage employees and their dependents, often through financial incentives, to "take ownership over their health and to participate in activities to improve their well-being."[105]

The premise behind workplace wellness programs is that if employees are healthier and consume less healthcare, then the employer will gain financially through lower health expenditures, reduced absenteeism, and more "presenteeism" by employees.[106] "Wellness

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[99] Jessica L. Roberts and Leah R. Fowler, How Assuming Autonomy may Undermine Wellness Programs, Health Matrix, Vol. 27, at 102 (2017).
[100] Kaiser Family Foundation Report, Employer Health Benefits 2023 Summary of Findings, at 4 (2023), available at https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey-Summary-of-Findings.pdf (last visited December 24, 2023).
[101] Kathryn Mayer, Growth in Total Compensation Cost Slows for Employers, Report from Society of Human Resource Managers (Sept. 12, 2023), available at https://www.shrm.org/resourcesandtools/hr-topics/compensation/pages/employer-costs-for-employee-compensation-bls-second-quarter-2023.aspx (last visited December 24, 2023).
[102] Report, Employers Anticipate 7% Rise in Health Care Costs for 2024, Society of Human Resource Managers (August 17, 2023), available at https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/employer-healthcare-cost-projection-2024-international-foundation-employee-benefit-plans.aspx (last visited December 24, 2023).
[103] Id.
[104] Carrie Griffin Basas, What's Bad About Wellness, at 1050 (noting that over time, chronic and lifestyle illnesses (e.g., heart disease, diabetes, cancer) associated with numerous stressors in life and the workplace became the primary health concern).
[105] Id., at 102-107 (2017) (citing 26 CFR § 54.9802-1(f) (2016)).
[106] Id. at 107.

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."[107]

Workplace wellness programs are growing in popularity. The percentage of large employers (200 or more workers) that offer a workplace wellness program grew from 70% in 2008 to 84% in 2019.[108] This amounts to 63 million employees in the United States who work for firms that offer workplace wellness programs.[109] In 2019, 72% of large employers asked employees to disclose extensive personal health information via a questionnaire (i.e., a "health risk assessment") or through biometric screening (such as a physical examination or lab test), or both.[110] Of those workplace wellness programs that collect health information, which may include measuring BMI or asking questions about weight, 54% of those programs tie financial incentives to that information collection.[111] Specifically, about seven percent of large employers offer incentives to employees who achieve a target BMI or cholesterol level.[112] For many employees, the amount of the financial incentive was valued at more than $1,000. Specifically, in 2019 20% of large firms offered such high financial incentives to employees who divulged sensitive health information as part of the workplace wellness programs.[113]

Another survey of U.S. worksites with at least ten employees found that 30.6 percent of surveyed employers tied financial incentives to achieving a health standard (which may include meeting a target BMI or quitting tobacco use as examples), and 18.2 percent screened employees for obesity.[114]

In addition to health information collection activities, other typical workplace wellness program activities include those that aim to help people lose weight, stop smoking or provide lifestyle and behavioral coaching.[115] Indeed, obesity programming at the workplace has significantly increased from 2004 to 2017, "likely because of the widely acknowledged epidemic of obesity among US adults."[116] To address obesity in the workplace, the survey found that over 65 percent of large employers (those with greater than 200 employees) offered weight loss programs to employees.[117] About 28.5 percent of all worksites offer physical activity programs and 23.1 percent offer nutrition

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[107] Id.
[108] Matthew Rae, Trends in Workplace Wellness Programs and Evolving Federal Standards, Kaiser Family Foundation (June 9, 2020), available at https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards/ (last visited December 25, 2023).
[109] Id.
[110] Id.
[111] Id.
[112] Id.
[113] Id.
[114] Laura A. Linnan, et al., Results of the Workplace Health in America Survey, Am. J. Health Promotion, Vo. 33, at 652—665 (June, 2019).
[115] Matthew Rae, Trends in Workplace Wellness Programs and Evolving Federal Standards, Kaiser Family Foundation (June 9, 2020), available at https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards/ (last visited December 25, 2023).
[116] Id.
[117] Id.

programs.[118] Only 20 percent of surveyed employers offer evidence-based health programming.[119] Of those employers that offered physical activity programs, 15.3 percent offered self-management programs with advice on physical activity, only.[120] Of those that offered nutrition programs, 43 percent offered nutrition information only.[121] In other words, a lot of workplace wellness programs consist of programs that are not evidence-based and merely give employees information about healthy living with no follow up or exploration as to whether the employees can actually implement healthy living practices.

About one in five surveyed employers offer more comprehensive health promotion programs. The survey defined "comprehensive health promotion program" to include the following five elements: 1) health education programs; 2) supportive social and physical work environment; 3) integration of the program into the organization's structure, 4) linkage to related programs such as employee assistance programs (EAPs); and 5) health screening with appropriate follow-up and education.[122]

B. Workplace Wellness Laws

Workplace wellness programs are recognized in several federal and state statutes. The two most relevant for this article are the Affordable Care Act (ACA) and the Americans with Disabilities Act (ADA).

1. ACA

The ACA divides wellness program activities into two groups: (1) participatory and (2) health contingent. Health-contingent programs are further divided between activity-only and outcomes-based programs.

In a participatory wellness program, a participant earns financial incentives merely through engagement with the program.[123] The participant is not expected to achieve a certain wellness goal, such as meeting a certain BMI, in exchange for receiving a "reward" (which could be a discount or rebate of a health insurance premium or other cost-sharing, an additional benefit, financial or other incentive, as well as avoiding a penalty).[124]

Health contingent wellness programs require participants to meet a certain health goal in exchange for a reward, such as a healthy BMI or completing an activity that invokes a health factor.[125] These health contingent programs are further divided into "outcomes-based" wellness programs, which tie incentives to meeting a certain health measure (like

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[118] Id.
[119] Id.
[120] Id.
[121] Id.
[122] Id. Supportive environments might include walking trails, bike racks, showers, paid time off to be physically active, smoking restrictions, food preparation and storage facilities, or on-site health clinics.
[123] 45 CFR § 146.121(f).
[124] 45 CFR §. 146.121(f)(1)(i).
[125] 45 CFR § 146.121(f)(1)(iii).

BMI)[126] and "activity-based" for programs that tie incentives to an activity that not everyone can do or may have difficulty doing because of a health factor (e.g., a running program may be difficult for someone with asthma).[127] Some examples of activity-only programs are walking, diet, or exercise programs.[128]

To be compliant with the ACA wellness incentive rules, participatory programs merely need to be offered to all "similarly situated employees."[129] Health contingent wellness programs must meet a five factor test to be compliant with the ACA wellness incentive rules.[130] Those five factors are: 1) the program must give program-eligible individuals the opportunity to qualify for the reward at least once per year; 2) the value of the reward may not exceed 30 percent of the total cost of employee-only or family coverage (depending on the type of plan in which employee is enrolled); 3) the program must be reasonably designed to promote health or prevent disease; 4) the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward if it is unreasonably difficult due to a medical condition for the employee to satisfy the original standard; and 5) the plan must notify employees of the availability of the reasonable alternative standard in all plan materials that describe the terms of the wellness program.[131]

Financial incentives often take the form of reduced health insurance premiums.[132] That is, if the employee and/or their dependents try to lead a "healthier life," they pay less for health insurance. Or, the incentive might be a different type of bonus, such as a gift card, novelty items like t-shirts, event tickets, or free or discounted gym memberships.[133] In any case, the workplace wellness program celebrates and rewards employees who choose healthier lifestyles.

In summary, the ACA workplace wellness law allows financial incentives in wellness programs tied to group health plans that may offer a wide variety of wellness program activities. These activities span from exercise and diet programs to health information collection activities (such as BMI) and tie financial rewards to completing those activities or meeting certain metric benchmarks. If the wellness program is merely participatory, there are no requirements under the ACA wellness incentive rules other than the program must be offered to all similarly situated employees. There is no requirement that the program be reasonably designed to promote health or prevent disease. Health contingent wellness programs must meet more requirements, including being reasonably designed to promote health and prevent disease, but the ACA wellness incentive rules purposely leave that requirement vague.

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[126] 45 CFR § 146.121(f)(1)(v).
[127] 45 CFR § 146.121(f)(1)(iv).
[128] Id.
[129] 45 CFR § 146.121(f)(2).
[130] 45 CFR § 146.121(f)(3) (activity-based) and (4) (outcomes-based).
[131] Id.
[132] Jessica L. Roberts and Leah R. Fowler, How Assuming Autonomy may Undermine Wellness Programs, Health Matrix, Vol. 27, at 113 (2017).
[133] Id. at 113.

Specifically, in the preamble to the ACA wellness incentive rules, some commenters requested the Departments of Labor, Health and Treasury ("Departments") to require that all wellness programs be based on evidence-based clinical guidelines and national standards established by bodies such as the Centers for Disease Control (CDC), Centers for Medicare & Medicaid Services (CMS), or the National Institutes of Health (NIH).[134] The Departments declined that request, stating that workplace wellness programs are not required to be accredited or based on particular evidence-based clinical standards.[135]

Rather, the Departments wanted to provide plans with "flexibility and encourage innovation."[136] Under the ACA wellness incentive rules, workplace wellness programs are reasonably designed if they have a "reasonable chance" to promote health or prevent disease, are not overly burdensome, are not a subterfuge for discrimination based on a health factor, and are not highly suspect in the method chosen to promote health or prevent disease.[137] According to the Departments, reasonable design is based on "all the relevant facts and circumstances."[138]

2. ADA

Title I of the ADA prohibits discrimination by employers on the basis of disability in regard to terms, conditions, and privileges of employment.[139] ADA discrimination includes requiring medical examinations and making disability-related inquiries, including medical history inquiries, unless one of two exceptions applies: 1) such exam or inquiry is job-related and consistent with business necessity;[140] or 2) the medical exam is *voluntary* and part of an employee health program available at the worksite.[141]

The key term for ADA workplace wellness program compliance is the word *voluntary,* which unfortunately is not defined in the ADA statute.[142] Nevertheless, the ADA permits employee medical exams and inquiries if they are part of a voluntary workplace wellness program. Current guidance from the Equal Employment Opportunity Commission (EEOC) regarding the meaning of "voluntary" is that the employer can neither require participation nor penalize employees who do not participate.[143] Voluntary medical exams and inquiries

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[134] 78 Fed. Reg. 33158, 33162 (June 3, 2013).
[135] Id.
[136] Id; see also Strassle and Berkman, at 14 (noting that current workplace wellness laws were passed in a period when wellness program risks and benefits were understood differently and that policymakers wanted to give employers the flexibility to create different programs, hoping that innovations in wellness would appeal to employees, increase productivity, and protect the workforce from preventable health conditions).
[137] 78 Fed. Reg. 33158, 33162 (June 3, 2013).
[138] Id.
[139] 29 USC § 12112(a).
[140] 29 USC § 12112(d)(4)(A).
[141] 29 USC § 12112(d)(4)(B) (emphasis added).
[142] AARP v. EEOC, 267 F.Supp.3d 14, 20 (Dist. Ct. D.C. Aug. 22, 2017)
[143] EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations, No. 915.002 (July 27, 2000), available at https://www.eeoc.gov/laws/guidance/enforcement-guidance-disability-related-inquiries-and-medical-examinations-employees (last visited December 26, 2023). The EEOC did promulgate rules to further define "voluntary" as allowing employers to offer incentives tied to health information collection if those incentives did not exceed 30% of the total cost of self-only health coverage.

might take the form of biometric screens or health risk assessments, both of which may measure an employee's BMI.[144]

In contrast to the ACA, which applies to wellness programs that qualify as "group health plans,[145] the ADA applies to all workplace wellness programs that collect health information from employees.[146] It does not apply to other types of wellness activities such as exercise or diet programs.[147] The voluntary requirement may apply to tobacco cessation programs if the data collection uses a biometric screen to measure the presence of nicotine or tobacco.[148] But otherwise, the ADA's application to workplace wellness programs applies narrowly to health information collection activities by employers.

In promulgating the ADA wellness rules, the EEOC also rejected comments that wellness programs should be based on clinical guidelines or national standards.[149] Instead, the EEOC adopts the similar requirement as the ACA rules for health contingent wellness programs: that the program be reasonably designed to promote health or prevent disease.[150] The program merely must have a "reasonable chance of improving the health of, or preventing disease in, participating employees and must not be overly burdensome, a subterfuge for violating the ADA or other laws prohibiting employment discrimination, or highly suspect in the method chosen to promote health or prevent disease."[151]

As an example, the EEOC states that programs that collect health information from employees "without providing results, follow-up information, or advice designed to improve the health of participating employees would not be reasonably designed to promote health or prevent disease, unless the collected information actually is used to design a program that addresses at least a subset of conditions identified."[152] But, follow-

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See 81 Fed. Reg. at 31126, 31128 (May 17, 2016). However, the EEOC revoked the incentive rules on January 1, 2019, as ordered by the court in AARP v. EEOC, 292 F.Supp.3d 238 (Dec. 20, 2017). As a result, the only guidance regarding the meaning of "voluntary" wellness program is the EEOC Enforcement Guidance from 2000.

[144] 81 Fed. Reg. 31126, 31140 (May 17, 2016) (stating that asking employees to complete an HRA and/or undergo a biometric screening for the purpose of alerting them to health risks of which they may have been unaware would meet the standard that a program is reasonably designed to promote health and prevent disease).

[145] 78 Fed. Reg. 33158 (June 3, 2013) (noting that the wellness exception to Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination provisions, which were amended by the ACA, applies to group health plans as defined by part 7 of the Employee Retirement Income Security Act (ERISA)).

[146] 81 Fed. Reg. 31126, 31132 (May 17, 2016) (stating that the ADA wellness program rules apply to wellness programs that are offered only to employees enrolled in an employer-sponsored group health plan, offered to all employees regardless of whether they are enrolled in such a plan, or offered as a benefit of employment by employers that do not sponsor a group health plan or group health insurance).

[147] Id. at 31141 (noting that not all wellness programs require disability-related inquiries or medical examinations to earn an incentive and that programs that include attending nutrition, weight loss or smoking cessation classes are not subject to the ADA incentive rules).

[148] Id. at 31136 (applying the ADA incentive rules to smoking cessation programs that require employees to be tested for nicotine use vs programs that merely ask employees whether they smoke).

[149] 81 Fed. Reg. 31126, 31132 (May 17, 2016).

[150] Id.

[151] Id. at 31133.

[152] Id.

up information or advice will not necessarily address the SDOH, and using information to design a program for employees invites a paternalistic approach to wellness program design. Rejecting evidence-based wellness programs will not give the results intended by workplace wellness programs: healthier and more productive employees. Although the EEOC acknowledges the possibility of unlawful discrimination in outcomes-based wellness programs, such as employees failing to attain a certain BMI, the EEOC states that such discrimination can be corrected by offering and providing a reasonable alternative standard.[153] Providing a reasonable alternative standard to individuals disproportionately affected by outcomes-based wellness programs will not address the implicit bias in the standard or wellness program overall; employees who do not meet the standard (whether BMI or some other wellness activity) will still be singled out as noncompliant and must jump through other hoops to "fit in" to whatever norm the employer has set.

C. The Implicit Bias in Workplace Wellness Programs and Laws

The ability for employers to engage in discriminatory practices through workplace wellness programs stems directly from the ACA and ADA. Not only do these two laws permit discrimination based on health status so long as the wellness programs meet the requirements of those two laws, which are not that onerous, neither law requires evidence-based wellness programs or evaluation of the wellness program to determine if it even works at improving overall health and lowering health care costs.[154] In fact, a workplace wellness program report by the RAND Corporation indicates that none of the employers studied by RAND conducted a formal evaluation of the impact of their wellness programs.[155] To the extent employers conduct any evaluation of their wellness programs, the evaluation mostly entails measuring employee satisfaction and participation in the program, not the impact on the participants' health or productivity.[156] As a result, there is little peer-reviewed research that shows workplace wellness programs are evidence-based and successful.[157] Indeed, a "growing body of literature suggests that wellness programs in their most common forms are generally not optimally designed to promote employee health."[158]

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[153] Id. at 31133 and 31143.
[154] Hermer, at 233 (citing Lindsay F. Wiley, Access to Health Care as an Incentive for Healthy Behavior? An Analysis of the ACA's Personal Responsibility for Wellness Reforms, 11 Ind. Health L. Rev. 635, 665 (2014) (finding that only about half of employers who have wellness programs report that they have evaluated them).
[155] Soeren Mattke, et al., Workplace Wellness Programs Study: Final Report, RAND Corporation, at 103 (2013), available at https://www.rand.org/pubs/research_reports/RR254.html (last visited December 26, 2023).
[156] Linnan, et al., at 14 (finding that worksites evaluating their wellness programs were more likely to collect process metrics such as employee participation (98.3% of those doing evaluation) or employee feedback (89.7%), whereas complex evaluation activities such as calculating return on investment were rarer, as was evaluating the impact of programs on participants' health or productivity).
[157] Roberts and Fowler, How Assuming Autonomy may Undermine Wellness Programs, at 104.
[158] Id.

1. Workplace Wellness Program Impact Studies

More recent and robust studies of workplace wellness programs confirm this result. Initial studies of workplace wellness programs showed promising and significant cost savings for employers that implemented such programs.[159] Closer analysis of these studies exposes their critical flaws and the very foundation on which these programs are based. The studies that showed successful workplace wellness programs in terms of cost savings for employers were inappropriately designed. For example, there were no comparison groups to the studied group, or the comparison group was not randomized.[160] The studies also had high levels of selection bias; the program participants differed systematically from nonparticipants, overstating the programs' effect.[161] The studies also suffered from small sample sizes, short measurement periods, overutilization of self-report measures and a lack of valid measures.[162] "Other common criticism 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."[163] As a result, the studies upon which the ACA wellness rules were built had serious flaws.

More recent studies paint a different picture of workplace wellness program effectiveness. These newer, appropriately designed studies, show no impact on medical expenditures, health behaviors, employee productivity, or self-reported health status.[164] A study by the RAND Corporation showed the return on investment in workplace wellness programs is only fifty cents per every dollar spent on the program.[165] The reputable studies regarding workplace wellness program impact that do exist show 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.[166] Based on the whitewashing of the wellness industry discussed earlier, it would make sense that the employees most attracted to workplace wellness programs would be those who identify most closely with the wellness target market.

2. Workplace Wellness Program Bias

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[159] Strassle and Berkman, at 1668-69 (citing case studies by Johnson & Johnson, Bank of America, the California Public Employees Retirement System, Citibank Health Management Program, and Safeway, as well as a high-profile meta-analysis published in 2010 that showed for every dollar spent on a workplace wellness program, medical costs fell by about $3.27 and absenteeism costs fell by about $2.73).
[160] Id. at 1671-72.
[161] Id.
[162] Id. at 1670.
[163] Roberts and Fowler, at 111.
[164] Strassle and Berkman, at 1674; see also Hermer, at 233-35 (citing two recent workplace wellness studies that found no statistically significant effect of wellness program participation on health care spending, employee productivity, or employee health behaviors).
[165] Roberts and Fowler, at 112 (citing RAND Corp, Do Workplace Wellness Programs Save Employers Money? (2014)).
[166] Id.

Against the backdrop of an implicitly biased wellness industry, it should be no surprise that workplace wellness programs, which are just a microcosm of the larger wellness industry, also discriminate against, disrespect and disregard historically marginalized people. Employers often contract with wellness vendors to provide or lead wellness programs and activities.[167] That means the individuals conducting wellness programs, whether it is a fitness or diet program, are predominantly white, physically able females who do not adequately represent historically marginalized people. Just as in health care, this lack of diversity in wellness service providers likely undermines the ability of employees from more diverse backgrounds to trust that the wellness provider understands their needs.[168] The lack of diversity in the wellness workforce also reinforces the stereotypical healthy body as thin, white, female, and physically fit because that is the role model employees see. Without cultural competency training for employers and wellness service providers, adopting workplace wellness activities like yoga and mindfulness ignores cultural appropriation perspectives and calls into question the true purpose behind workplace wellness efforts.

Workplace wellness programs that emphasize and incentivize individual behavior choice, such as getting more exercise, eating better, stopping use of tobacco, and learning about "self-care" assume that employees have the ability to make meaningful choices about their health.[169] Workplace wellness programs that fail to account for SDOH, including systemic racism and ableism, "thwart efforts to adopt healthier behaviors."[170] And those individuals who do manage to meet wellness targets despite SDOH further divides them from others who cannot and "moralizes the failure of the latter while privileging the conformity of the former."[171] The focus shifts again to the individual's ability to control their health rather than creating a change in the environment, values and systems that offer care and understanding for individuals who do not fit within the paternalistic "wellness ideal."[172]

Tying financial incentives to meeting an implicitly biased measure like BMI is also prevalent. As noted above, about seven percent of large employers tie incentives to

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[167] Laura Linnan, et al., Results of the Workplace Health in America Survey, Am. J. Health Promot., Vol. 33(5), 652-665 (June 2019) (noting that 8.1% of physical activity programs were offered mostly by a vendor and 13% of nutrition programs were offered by a vendor).; see also Camila Strassle and Benjamin E. Berkman, Workplace Wellness Programs: Empirical Doubt, Legal Ambiguity, and Conceptual Confusion, 61 William and Mary L. Rev., 1663, 1716 (May 2020) (noting that many employers contract with third-party vendors to deliver wellness services).

[168] Report, Leslie Read, Heather Nelson and Leslie Korenda, Rebuilding Trust in Health Care, Deloitte Insights, at 1-2 (2021), available at https://www2.deloitte.com/us/en/insights/industry/health-care/trust-in-health-care-system.html (last visited December 20, 2023) (noting that having a provider who has empathy, is culturally competent, and /or looks like them is a top priority for health care consumers who identify as Black, Asian, Hispanic, and Native American).

[169] Roberts and Fowler, at 105.

[170] Id.

[171] Basas, at 1053.

[172] Id.

achieving biometric outcomes such as a target BMI.[173] These incentives often include higher health insurance premiums if an employee fails to meet a certain outcome, such as a certain BMI level. Employer use of the one-size-fits all BMI unfairly punishes historically marginalized groups, particularly black women, because what constitutes an unhealthy BMI for black women is on a much higher scale than what an employer typically uses to determine whether an employee has an unhealthy BMI. In other words, black women pay higher health insurance premiums because of a supposed high BMI even though they are not likely at risk for the diseases that presumably cost the employer plan a lot of money.

Health contingent wellness programs also unfairly punish more broadly those from more challenging social and economic backgrounds. For example, in one "play or pay" model wellness program, employees who refused to participate or "play" in the wellness program had to pay $35 extra per month for their benefits.[174] A study that examined this play or pay program found that nonparticipants were more likely to earn less than $40,000 per year, have a lower level of education, and /or have at least one health risk factor, such as obesity or smoking.[175] In essence, workplace wellness programs impose higher health care costs on individuals from lower socioeconomic classes, who often overlap with historically marginalized groups. [176] In other words, the very people who are least likely able to bear the burden of higher health care costs are likely the most adversely impacted by workplace wellness programs. It is legally sanctioned discrimination against some of the most vulnerable and disenfranchised members of society.

One recent lawsuit highlighted the disproportionate impact wellness program financial incentives have on those with lower socioeconomic status and those with disabilities. In *AARP v. EEOC*, the AARP, a consumer advocacy organization, sued the EEOC under the Administrative Procedure Act (APA) arguing that the ADA wellness incentive rules promulgated in 2016 violated the ADA.[177] The AARP's principle argument was that the ADA wellness incentive rule that allowed employers to impose incentives valued up to 30 percent of the total cost of self-only health coverage was inconsistent with the ADA's "voluntary" requirement.[178] The District Court agreed and criticized the EEOC for failing to consider the disproportionate impact the 30 percent incentive level would have on employees with lower incomes, who are often employees

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[173] Matthew Rae, Trends in Workplace Wellness Programs and Evolving Federal Standards, Kaiser Family Foundation, at (June 9, 2020), available at https://www.kff.org/private-insurance/issue-brief/trends-in-workplace-wellness-programs-and-evolving-federal-standards/ (hereinafter "KFF Survey"). y

[174] Herman, The Means and Ends of Wellness Programs, at 238-239.

[175] Id.

[176] Roberts and Fowler, at 112 (citing Jill Horwitz's theory that the savings resulting from workplace wellness programs may be the result of cost-shifting from healthy workers to unhealthy workers and that lower-income workers often overlap with historically disadvantaged minority populations); see also Hermer, The Means and Ends of Wellness Programs, at 237 (stating that the low participation rate for employees in health contingent wellness programs suggests that these wellness plans both can be and are being used as a means for employers to shift costs onto less healthy employees).

[177] AARP v. EEOC, 267 F.Supp.3d 14 (D.D.C. 2017). The AARP also argued the EEOC violated the Genetic Information Nondiscrimination Act (GINA), but this article focuses solely on the ADA rules.

[178] Id. at 21.

with disabilities.[179] The court slammed the EEOC for failing to give sufficient thought to whether or how it should apply a permissible incentive level in the context of the ADA, and particularly in the context of the ADA's "voluntary" requirement.[180] Instead, the court accused the EEOC of "just "co-opting" the 30 percent incentive level from the ACA wellness incentive rule.[181] In a sense, then, the EEOC did what other wellness industry stakeholders in the United States have done, which is to jump on the wellness bandwagon without considering who truly benefits from wellness or how wellness could be more inclusive and helpful for everyone.

With all this evidence about workplace wellness programs being biased and not working as intended, one may logically ask whether such programs are even worth pursuing.

D. Is Employee Wellness Worth Pursuing?

Even with all the implicit bias and abysmal results in workplace wellness, striving for wellbeing at work is worth pursuing. As noted by Carrie Griffin Basas, "[w]orkers should be provided with environments that do not exacerbate or introduce new forms of disability."[182] Countless research shows that adopting healthy lifestyle changes does lead to positive health outcomes.[183] The trouble is, there is no research that shows wellness programs as currently designed and implemented help all populations equally. Very little data exists to show the specific impact wellness programs have on minority populations.[184] As the McKinsey wellness market study finds, 47 to 55 percent of Black consumers said they needed more wellness products and services to meet their needs, and 60 percent of Black consumers prioritized their wellness more in 2022 than 2021.[185] It's not that historically disadvantaged people don't want wellness, it's just that the wellness industry, including workplace wellness, hasn't had their best interests in mind. People who have been historically harmed by the dominant culture have seen their cultural traditions co-opted for profit, have been ignored regarding systemic and structural barriers to achieve wellness and then have been blamed and financially penalized for not meeting norms that were never meant for them. Wellness should be for everyone, as Rina Raphael proclaims in her book *The Gospel of Wellness*.[186] But the current state of wellness efforts needs a paradigm shift if it is to be more equitably distributed. Neither health nor wellness should be "associated with class, image, or five-star hotel pools."[187]

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[179] Id. at 33 ("The possibility that the ADA rule could disproportionately harm the group the ADA is designed to protect would appear to pose a 'significant problem.'").
[180] Id. at 34.
[181] Id.
[182] Carrie Griffin Basas, What's Bad about Wellness? What the Disability Rights Perspective Offers about the Limitations of Wellness, J. Health Politics, Policy, and Law, at 1050, Vol. 39 (Oct. 2014).
[183] Roberts and Fowler, at 110-111 (noting that adults participating in consistent physical activity have been shown to exhibit a 20 to 30 percent reduction in risk for premature death and up to 50 percent reduction in chronic conditions such as diabetes or cancer).
[184] Id.
[185] McKinsey, Still Feeling Good, at 10.
[186] Raphael, at 282.
[187] Id. at 278 and 283 (asking "How did wellness, the pursuit of health, become associated with luxury?"); see also Ruqalijah Yearby, Brietta Clark, and Jose F. Figueroa, Structural Racism in Historical and Modern US Health Care Policy, 41 Health Affairs, 187, 191 (February 2022) (stating that "Structural racism in

The paradigm shift needed in wellness should revert to its earlier definition by Halbert Dunn: maximizing health while considering one's environment. Considering the structural, systemic, social, physical, and economic environment that impacts individual wellbeing has a better chance of improving the wellbeing of all people rather than those who are currently privileged to already have a good dose of health and wellness. Rather than projecting an ideal wellness image, those working to improve individual wellbeing should focus more on "principles of community and interdependence to find support" for individual needs and strengths.[188]

Instead of focusing exclusively on individual behavior and lifestyle choices, workplace wellness programs must incorporate the bigger picture and acknowledge that not everything is in an employee's control. It is unjust to hold employees accountable for their health status when those employees are already disadvantaged because of SDOH.[189] "If we actually cared about the health and well-being of individuals, we would make it easier for them to buy and make healthy food, live in pleasant, reasonably safe, and well-designed neighborhoods with plenty of opportunities for recreation, and foster vibrant communities where curiosity is encouraged and where people have multiple opportunities to connect and become involved, in an effort to build strong societies and improve mental health. But we do not."[190] It is far easier to place responsibility for health and wellness on individuals than tackle the SDOH that precipitate poor health.[191] When individuals fail at their personal responsibility, it is far easier for employers and the government to help pay for someone to take a pill or get surgery than to tackle the root cause of illness such as by "diminishing pollution and encouraging both exercise and healthier eating through structural changes in society."[192]

Changing the paradigm to embrace SDOH in wellness will not be an easy feat. Wellness needs champions and advocates to help workplace wellness programs find a balance between empowering employees to preserve and promote their own health while not holding them solely accountable for their current health status. These advocates must shift the focus from blaming employees for their health status to addressing the root causes of poor wellbeing. One way to develop these champions to help tackle root causes of poor wellbeing is through Wellness-Legal Partnerships.

[health care] coverage and financing has created a two-tier system of racially segregated care in which minority people receive poorer-quality care.").

[188] Basas at 1062.

[189] Ben Schwan, Responsibility Amid the Social Determinants of Health, Bioethics, Vol. 35, at 13 (2021).

[190] Hermer, at 251.

[191] Id. at 251-252.

[192] Id. at 250-252 (noting that while individuals are being penalized by making what employers or states consider to be poor health choices, many industries are largely free to market unhealthy products to these same individuals that are low-nutrient, highly-processed foods, that state and private developers are relatively free to design communities that foreclose opportunities for residents to exercise, associate easily with others, enjoy peaceful green space).

III. How Wellness Legal Partnerships Can Improve Workplace Wellness

Despite the glaring flaws in workplace wellness laws when it comes to bias against historically marginalized individuals, the law can step in and improve employee wellbeing through Wellness-Legal Partnerships (WLPs). WLPs can be modeled after Medical-Legal Partnerships (MLPs), which have been around for decades. After providing a brief overview of MLPs, this part will explain how WLPs can boost the effectiveness of workplace wellness programs and how employers could implement WLPs in the workplace.

A. MLP Overview

MLPs are a construct of the health care industry, which is guilty of inequity at least as much as the wellness industry. According to one recent article about structural racism in U.S. health care policy, value-based payment reform, which ties provider payments to improved health care quality, fails to account for how SDOH shape health status and need when determining provider performance, ranking and payment.[193] As a result, safety net providers are penalized with lower Medicare reimbursement under these value-based programs because they care for low-income minority people with poorer health status.[194] In contrast, value-based payment programs reward providers that care for more affluent and White populations.[195] Just like wellness, in health care it is much easier to create programs that help the low hanging fruit (i.e., the dominant culture) than it is to create a program that distributes resources equitably.[196]

MLPs were born to combat this inequity in health care.[197] The first formal MLP was founded by Dr. Barry Zuckerman at Boston Medical Children's Center in 1993.[198] Before that, however, health care providers and civil legal aid attorneys collaborated during the 1980s to combat the emerging HIV/AIDS crisis.[199] Today, over 450 health organizations have developed MLPs in 49 states and Washington, D.C.[200] MLPs have the support of the Health Resources and Services Administration, the U.S. Department of Veterans Affairs,

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[193] Ruqalijah Yearby, Brietta Clark, and Jose F. Figueroa, Structural Racism in Historical and Modern US Health Care Policy, 41 Health Affairs, 187, 191 (February 2022)
[194] Id.
[195] Id.
[196] Raphael, at 277 (finding that luxury wellness seems to be winning over more democratic models because it is much easier to target the one percent than it is to really come up with a model for the ninety-five percent).
[197] Dana Bowen Matthew, Medical-Legal Partnerships and Mental Health: Qualitative Evidence that Integrating Legal Services and Health Care Improves Family Well-Being, 17 Hous. J. Health L. & Policy, 343, 347 (2017) (asserting that medical-legal partnerships help low income and underserved populations improve their health and health care by addressing legal issues that adversely affect the social determinants of health).
[198] Id. at 349.
[199] Id. at 349.
[200] Fact Sheet, National Center for Medical-Legal Partnership, available at https://medical-legalpartnership.org/ (last visited December 27, 2023).

the Association of American Medical Colleges, and other professional medical associations.[201]

MLP structures and operations vary tremendously, from merely a referral service by a medical partner to a legal partner, to more fully integrated models where the MLP attorney works collaboratively with clinicians to jointly address patient clinical and non-clinical needs.[202] Regardless of how they are structured, at the heart of MLPs is collaboration between medical and legal professionals. MLPs employ a preventive lawyering, holistic, collaborative and interdisciplinary approach to health care by joining lawyers and healthcare providers to improve health status, especially for patients from historically marginalized backgrounds who are affected by health disparities.[203] "When professionals collaborate, and consider medical and legal problems in their social context, they broaden their ability to address those problems and serve patients and clients in ways that they could never do as individuals."[204]

MLPs typically engage in three types of activities: 1) MLP lawyers provide legal representation to address adverse social conditions for which there are legal remedies (such as requiring landlords to remove lead paint toxins or mold, appealing wrongful public benefit terminations, and enforcing educational accommodations for disabled children); 2) MLPs transform health and legal institutional practices by training clinical providers to screen for and identify patients' social and legal needs during office visits; and 3) MLPs advocate for structural policy changes at an institutional, local, state, and federal level through a "patients-to-policy" approach.[205] The "patients-to-policy" approach means that through individual advocacy, "MLP lawyers and their health care partners listen to the concerns of clients and identify policies and practices that have harmful impacts – and then advocate for long-term systemic solutions, promoting population wellness and structural justice."[206]

MLPs serve a wide variety of clients, including children, the elderly, immigrants, Native Americans, or adult patients with complex co-morbidities who frequently use

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[201] Id.
[202] Jessica Mantel and Leah Fowler, A Qualitative Study of the Promises and perils of Medical-Legal Partnerships, 12 Northeastern U. L. Rev., at 8-9 (2020), available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3694038# (last visited December 27, 2023).
[203] Lisa Bliss, et al., An Interdisciplinary Collaborative Approach to Wellness: Adding Lawyers to the Healthcare Team to Provide Integrated Care for Patients, 1 Int'l J. Health, Wellness & Soc'y 129, 130 (2011); see also Emily A. Benfer, Abbe R. Gluck, and Katherine L. Kraschel, Medical-Legal Partnership: Lessons from Five Diverse MLPs in New Haven, Connecticut, 46 J. of Law, Medicine & Ethics, 602, 602 (2018) (stating that confronting social determinants demands a shift from the legal triage that occurs after a client suffers harm to a preventative lawyering approach).
[204] Lisa Bliss, et al., An Interdisciplinary Collaborative Approach to Wellness: Adding Lawyers to the Healthcare Team to Provide Integrated Care for Patients, 1 Int'l J. Health, Wellness & Soc'y 129, 134 (2011).
[205] Matthew, at 349; see also Cannon, at 74 (listing as typical duties of MLP lawyers to include training nonlawyer partners to understand and screen for legal issues; providing legal information, resources, and referrals; advocating around problems that are often intertwined with health and well-being; and facilitating structural change through a "patients-to-policy" approach).
[206] Id. at 79.

emergency and social services.[207] Some MLPs focus on a specific public health legal issue, advocating for legislative change to address identified population health problems.[208]

Studies of MLPs show that they improve patient physical and mental health by lowering stress levels and improving patient adherence to medical advice, reduce emergency department visits and inpatient admissions, increase use of preventive care, improve access to food and income supports, improve housing, and reduce energy insecurity.[209] MLP research has also shown a return on investment for hospitals and healthcare systems, which are common MLP sponsors.[210]

B. How WLPs Can Address Wellness Bias

Before diving into creating WLPs, it is important to acknowledge that the legal industry lacks significant involvement, much less leadership, in the wellness industry. At the time of this article's publication, there is no official recognition of "wellness law" as a legal practice area. But there should be. As highlighted in the introduction to this article, the wellness industry is thriving and growing. The legal industry should devote resources to this burgeoning wellness field for the very reasons outlined in this article: to draw attention to and fight against the injustices that wellness efforts wage on many people. WLPs are a good place to start this formal recognition by lawyers and legal leadership.

First, this author suggests that WLPs start with workplace wellness program partnerships before advancing to the broader wellness industry. To establish proof of concept, WLPs should start small, like MLPs did by starting with the HIV/AIDS crisis. Establishing WLPs inside a corporate wellness program makes the mission of addressing SDOH more manageable by focusing on a narrow population of employees who are supposed to benefit from the workplace wellness program.

Adopting the flexible structure and operation of MLPs, WLPs could similarly function in a variety of ways depending on the needs of the employee wellness program participants. Some roles WLPs could play to address the implicit bias in wellness described in this article include:

1. **Individual Employee Assistance**. Wellness providers could identify employees who may face social or structural barriers to wellness, such as domestic problems, discriminatory treatment, caregiving responsibilities that could be aided with public assistance, housing concerns, or estate planning concerns. Lawyers that staff the WLP could address those civil legal needs directly or refer employees to

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[207] Id. at 350.
[208] Id. at 350-51 (citing examples involving MLPs that worked to address lead poisoning in children and utility shut-off notice issues).
[209] Mantel and Fowler, at 52-54.
[210] Yael Cannon, Medical-Legal Partnership as a Model for Access to Justice, 75 Stanford L. Rev., 73, 75 (2023). Other medical partners include health centers, community clinics, and Veterans Administration medical centers. Benfer, Gluck and Kraschel, at 603.

other WLP partners such as financial or accounting experts or community social workers. Offering assistance to address SDOH will help workplace wellness programs move beyond their current emphasis on personal responsibility and recognize the social and environmental impacts of wellbeing.

2. **Employer and Wellness Provider Training**. WLPs can train corporate leadership and wellness service providers on cultural competence and implicit bias in wellness practice. Such training could help create wellness programs that are more sensitive to the various needs and views of employees and prevent unfair penalties from biased health measures or normative health expectations that are insensitive to body and cultural diversity.
3. **Wellness Program Evaluation**. Like the MLP "patients-to-policy" approach, WLP lawyers can implement an "employees-to-policy" approach by listening to employee clients and keeping track of their concerns and outcomes. From the WLP information gathering, WLPs can improve program evaluation efforts, which wil be important to sustain WLP existence and funding. MLPs need to demonstrate their value through outcomes research to ensure efficient operations and sustainable funding.[211] Because outcomes research is integral to MLP success, it should also be central to WLP success. WLP evaluation will help close the current gap on research into workplace wellness program overall effectiveness, as well as impact on historically marginalized individuals.
4. **Workplace Wellness Advocacy**. Lawyers involved with WLPs can give voice to the most vulnerable employees by ensuring that workplace wellness efforts work for them. In addition to offering civil legal assistance, WLP lawyers can also advocate for regulatory reforms at the local, state, and national level, as well as organizational change by the employer sponsors of the wellness program. For example, WLPs could advocate for more evidence-based workplace wellness programs to fulfill the reasonable design requirement under the ACA and ADA, and push for reasonable design, evidence-based standards in ACA participatory programs.[212] WLPs could also hold governments and employers accountable to do their part in ensuring wellbeing instead of shifting the responsibility solely to individuals. Specifically, WLPs could educate employers about the harmful and disproportionate impact paternalistic programs, such as health contingent programs, have on historically marginalized employees.[213] WLP lawyers could advocate to employers for programs that tackle social and structural barriers to health, such as better employment conditions, or providing a worksite farmer's market or end-of-day shuttle to the local health food store rather than a gift card to an inaccessible grocery store.[214] WLP lawyers could also hold governments accountable to ensuring the existence of necessary preconditions for living a

[211] Mantel and Fowler, at 45.
[212] Strassle and Berkman, at 42 (noting that evaluation of programs or seeking evidence-based practices could be used as evidence of reasonable design).
[213] Hermer, at 248 (stating that health-contingent wellness programs take a paternalistic approach).
[214] Roberts and Fowler, at 118 (suggesting that wellness programs that encourage healthy food choices substitute gift cards to grocery stores that are inaccessible or inconvenient to employees who live in food deserts with an onsite farmer's market).

healthy life, such as addressing pollution, food deserts and food swamps, and more opportunities to exercise and enjoy peaceful green spaces.[215]

The bottom line with all these roles for WLPs is that lawyers can and should play an essential role in the wellness industry, starting with workplace wellness programs. Lawyers can balance out the current one-sided view that wellness is primarily a choice by bringing SDOH factors into the equation. Lawyers are bringing such balance to health care through MLPs, they can also bring it to wellness through WLPs.

C. A Roadmap for WLP Implementation

One way to implement WLPs in workplace wellness programs is through Employee Assistance Programs (EAPs), specifically those adopted by Certified B Corporations.

According to the Departments, "EAPs are typically programs offered by employers that can provide a wide-ranging set of benefits to address circumstances that might otherwise adversely affect employees' work and health."[216] EAP benefits may include referral services, short-term substance use disorder or mental health counseling, or financial counseling *and legal services*.[217] The Departments acknowledge there is no universal definition of EAPs, offering flexibility in how employers use them.[218]

According to the Bureau of Labor Statistics, in 2023 75 percent of union workers in the United States had access to EAPs and 52 percent of nonunion workers had access to EAPs.[219] Though there is no universal definition of EAPs, they have traditionally been associated with mental health services, creating some stigma around their use.[220] Indeed, recent studies have estimated employee EAP utilization below 10 percent.[221] Employers are actively looking for ways to boost utilization of this very prevalent, but underutilized resource.[222] Offering a WLP through the EAP, in conjunction with an employer's workplace wellness program, might provide a solution, particularly for Certified B Corporations.

"B Corp Certification is a designation that a business is meeting high standards of verified performance, accountability, and transparency on factors from employee benefits

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[215] Hermer, at 249-250 (suggesting that government cannot expect people to live a healthy life if they do not have the necessary preconditions for living such life).
[216] 79 Fed. Reg. 59130, 59132 (Oct. 1, 2014).
[217] Id. (Emphasis added.)
[218] Id.
[219] Press Release, Employee Benefits in the United States, Bureau of Labor Statistics, at 2 (September 21, 2023), available at https://www.bls.gov/news.release/pdf/ebs2.pdf (last visited December 28, 2023).
[220] Theresa Agovino, Companies Seek to Boost Low Usage of Employee Assistance Programs, Society of Human Resource Managers (Nov. 21, 2019), available at https://www.shrm.org/topics-tools/news/hr-magazine/companies-seek-to-boost-low-usage-employee-assistance-programs (last visited December 28, 2023).
[221] Id.
[222] Id.

and charitable giving to supply chain practices and input materials."[223] To achieve certification, a company must: 1) demonstrate high social and environmental performance by achieving a B Impact Assessment score of 80 or above and passing the B Lab's (the accrediting body) risk review; 2) Make a legal commitment by changing their corporate governance structure to be accountable to all stakeholders, not just shareholders, and achieve benefit corporation status if available in their jurisdiction; and 3) Exhibit transparency by allowing information about their performance measured against B Lab's standards to be publicly available on their B Corp profile on B Lab's website.[224] The B Impact Assessment measures, among other things, a company's impact on employees.[225] In essence, companies that choose to become Certified B Corporations devote significant time and resources for a designation that demonstrates commitment to advancing social and environmental issues.[226]

In 2022, there were 2,047 companies that became certified B Corporations.[227] In total there are over 6,100 B Corporations worldwide.[228] Some well-known companies that have achieved B Corporation status are Patagonia, Allbirds and Ben &Jerry's.[229] These companies want to showcase their commitment to being socially responsible, including by prioritizing employee mental and physical wellbeing.[230] Specifically, "B Corps are developing new wellness programs that nurture company culture in an era of remote and hybrid work, create more equitable and transparent programs, provide workplaces where people feel safe and accepted, and help shape resilient and sustainable work practices."[231]

Because of their commitment to social responsibility, including towards their employees, Certified B Corporations make the perfect incubator for developing and testing WLPs as part of a workplace wellness program. Certified B Corporations could house WLPs within their EAPs and connect the WLP to workplace wellness efforts to improve employee wellbeing by looking beyond individual behavior solutions. For example, one Certified B Corporation touted offering workers "free access to Calm, a mindfulness app that incudes guided meditations, breathing programs, stretching

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[223] Fact Sheet, About B Corp Certification: Measuring a Company's Entire Social and Environmental Impact, B Corporation Website, available at https://www.bcorporation.net/en-us/certification/ (last visited December 28, 2023).
[224] Id.
[225] Id.
[226] Ali Donaldson, To B Corp or Not to B Corp? For Many Founders, There's No question, Inc. Magazine, at 2-3 (May 15, 2023), available at https://www.inc.com/ali-donaldson/why-a-record-number-of-business-owners-are-embracing-b-corps.html (last visited December 28, 2023) (stating that B Corp certification is rooted in stakeholder capitalism, in which companies make it their mission to weigh the impact of their activities on all stakeholders – employees, customers, the community and the environment- rather than focus solely on shareholders and profits).
[227] Id.
[228] Id.
[229] Id.
[230] Id; see also Fact Sheet, Shaping Workplace Wellness Programs with Employees, B Lab Website (July 26, 2023), available at https://usca.bcorporation.net/zbtcz7z23zshaping-workplace-wellness-programs-with-employees/ (last visited December 28, 2023).
[231] Fact Sheet, Shaping Workplace Wellness Programs with Employees, B Lab Website (July 26, 2023), available at https://usca.bcorporation.net/zbtcz7z23zshaping-workplace-wellness-programs-with-employees/ (last visited December 28, 2023).

exercises, and sleep stories."[232] If this company added a WLP to its wellness strategy, it could learn about how some employees may view the meditation app as cultural appropriation of a religious practice, or that such an app is merely a band aid to more fundamental problems that are wrapped up in SDOH.

In any case, to be successful, WLPs need commitment from the organization's leadership, and B Corporation leaders are likely more ready to commit to WLPs than companies that do not have such status. As the MLP community has learned, success of MLPs requires strong backing from the medical partner's leadership.[233] Similarly, WLP success will likely hinge on sufficient support from the employer and wellness service providers. Since many employers already invest in EAPs, and B Corporations are openly committed to improving the workplace experience, WLPs may find a welcoming environment inside a Certified B Corporation's EAP.

Conclusion

The wellness industry is a large and growing sector of the U.S. economy, and many people, including governments, look to wellness to assign responsibility for health outcomes and costs. But the concept of wellness is currently biased against individuals from historically marginalized populations on many different levels. Too many wellness stakeholders are blind to this implicit bias. The legal community should recognize wellness law as a critical practice area that needs lawyer involvement to advocate for wellness justice. A good start would be through the development of WLPs. This author acknowledges that WLP's are not a panacea. WLPs will need to prove that they are an effective method to address wellness bias and improve wellness equity. Regardless, WLPs offer one way to begin shifting the focus of workplace wellness away from individual behavior, dominant culture ideals and opportunist ventures to more holistic approaches that prioritize upstream causes of poor wellbeing.

[232] Id.
[233] Mantel and Fowler, at 42 (stressing the necessity of strong backing from the medical organization's leadership with time and resources).