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Lessons from the Wellness Community to Address the Anti-Vaccination Movement

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Introduction

On January 23, 2015, the Centers for Disease Control and Prevention ("CDC") issued a health advisory declaring a multi-state outbreak of measles associated with travel to Disneyland Resort Theme Parks.[1] The advisory asked healthcare providers to ensure that all of their patients are current on the "MMR" (measles, mumps and rubella) vaccine.[2] High rates of vaccination within a population can eliminate the onset of measles.[3] This is called "herd immunity," meaning that a high rate of vaccination ensures the protection of the population, even those who have not been immunized.[4] For vaccinations to be effective, health professionals recommend a vaccination rate of about 95 percent of a community's population.[5] Most of the people linked to the Disneyland outbreak were not vaccinated.[6]

The current measles outbreak has revived the age-old debate of protecting individual liberties versus protecting the common good. One way that public health agencies and state legislatures are grappling with the measles outbreak is through strengthening vaccination laws. Yet, as the worksite wellness community has learned recently, compulsory participation is not a panacea. Although mandatory participation efforts increase compliance, some people will still resist, maybe even object by fighting back. As the recent cases brought by the Equal Employment Opportunity Commission ("EEOC") demonstrate, just because one has legal authority to institute a program does not make that program the right or only course of action.

If the ultimate goal is to achieve unified, voluntary compliance with vaccination, then public health agencies may benefit from adopting program implementation strategies from the worksite wellness community. These strategies include two essential concepts that aim to establish a positive culture for wellness program adoption: 1) leadership buy-in and promotion; and 2) creation of cohesive and diverse teams for implementation. In relation to the anti-vaccination movement specifically, public health agencies should acknowledge that many anti-vaccination individuals may see complementary and alternative medicine ("CAM") providers and that these providers are often excluded from traditional public health initiatives. Public health leaders who are willing to include CAM providers in vaccination education and adoption efforts may find an effective way to encourage more widespread vaccination.

Relevant Legal History of Anti-Vaccine Sentiment

More than 100 years ago, *Jacobson v. Massachusetts* cemented the states' police power as a mechanism to protect public health and safety. The case not only remains good law, but its relevance to today's measles outbreak is uncanny. In 1905, Plaintiff Henning Jacobson sued the Commonwealth of Massachusetts alleging that a Massachusetts statute requiring persons who decline the smallpox vaccination to pay a $5.00 forfeiture violated his rights under the Fourteenth Amendment to the U.S. Constitution. Specifically, he argued that the state law invaded his liberty and was "hostile to the inherent right of every free man to care for his own body and health in such a way as to him seems best."[7] In deciding to uphold the Massachusetts statute, the United States Supreme Court recognized the state's "police power," which allows a state to "enact quarantine laws and health laws of every description" to protect the public health and public safety.[8] In response to Mr. Jacobson's concern about invading his liberty, the Court stated:

> Real liberty for all could not exist under the operation of a principle which recognizes the right of each individual person to use his own, whether in respect of his person or his property, regardless of the injury that may be done to others…
>
> …Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will. It is only freedom from restraint under conditions essential to the equal enjoyment of the same right by others. It is, then, liberty regulated by law…
>
> …[I]t was the duty of the constituted authorities primarily to keep in view the welfare, comfort, and safety of the many, and not permit the interests of the many to be subordinated to the wishes or convenience of the few.[9]

The Court took judicial notice that it is a common belief of the people of Massachusetts that vaccination is a preventive tool against smallpox.[10] The Court stated that a common belief does not need to be universally held for a legislature to enact laws to protect the health and safety of the population.[11]

The More Things Change, the More They Stay the Same

Similar to the situation over 100 years ago, there is a debate about the right to decline the MMR vaccination without penalty. There are people who question the safety and effectiveness

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of the MMR vaccine. Some trace the current debate back to a 1998 announcement by a British doctor who said he found a relationship between the MMR vaccine and the onset of autism.[12] The British doctor's findings were widely and quickly rejected and British medical authorities stripped him of his medical license.[13] Dozens of epidemiological studies found no merit to his study, which was based on a tiny sample.[14] Nevertheless, the vaccine-autism link has continued to be accepted by some.[15] Some reject vaccines for religious reasons; others because they prefer alternative medicines and still others because of a pervasive mistrust of many national institutions, such as the pharmaceutical industry that profits from vaccines.[16]

Furthermore, most states allow residents to opt-out of vaccinations for religious, personal or philosophical reasons.[17] Parents have taken advantage of these vaccination exemption laws by choosing to forego vaccinating their children, causing the rate of vaccination in some communities to fall well below 90 percent, which as noted above, is insufficient to achieve herd immunity.[18] Thus, despite the CDC's declaration in 2000 that measles has been eradicated in the United States,[19] the country's recent measles outbreak (which was over 133 cases in at least seven states at the time of this writing)[20] proves that the battle is not over.

To fight the continuing anti-vaccination battle, a number of states are now seeking to strengthen vaccination laws. California, Maine, Michigan, Minnesota, Oregon and Washington are looking to tighten or eliminate exemptions from vaccines because of religious or philosophical reasons.[21] For example, Oregon has introduced a bill that would allow vaccination exemptions solely for medical reasons and no longer for religious, philosophical or personal reasons.[22] Most of these proposals are in the early stages of the legislative process; however, Michigan changed its rules in November 2014 to now require parents who want a non-medical exemption from vaccinations to receive education on the risks of not receiving a vaccine.[23] American Public Health Association ("APHA") executive director Dr. Georges Benjamin supported those efforts, stating that he hoped policymakers would strengthen their vaccine laws and not weaken them.[24]

Yet, some public health experts have expressed concern that a solely authoritarian approach to force vaccination may create a backlash.[25] According to one expert, law should work as a nudge, not a shove.[26] Indeed, as the worksite wellness community has learned from a flurry of recent lawsuits brought by the EEOC, imposing programs that fall within legal parameters is not always the best policy. The public health community could learn from these EEOC cases about possible rebellion from anti-vaccination supporters.

Learning from the EEOC Cases

The EEOC filed three lawsuits in mid-to-late 2014 against three different companies: *EEOC v. Orion Energy Systems* (Case No. 2:14-cv-1019), *EEOC v. Flambeau, Inc.* (Case No. 3:14-cv-638) and *EEOC v. Honeywell International, Inc.* (Case No. 14-cv-4517). In the *Orion Energy* case, the EEOC has alleged that Orion Energy implemented a wellness program that included a health risk assessment and fitness test for its employees.[27] The health risk assessment asked the employees medical history questions and had a blood work component.[28] According to the EEOC complaint, Orion Energy required nonparticipants in the program to pay the entire premium cost of their health insurance coverage, while Orion Energy paid much of the cost of coverage for employees participating in the program.[29]

Similarly, the EEOC alleged that Flambeau implemented a wellness program that required employees to undergo biometric testing and a health risk assessment.[30] According to the EEOC, employees who fail to complete the biometric test and health risk assessment are responsible for paying 100 percent of their health insurance premium, while employees completing the test and health risk assessment paid a much lower cost.[31]

Finally, in the *Honeywell* case, the EEOC alleged that Honeywell required its High Deductible Health Plan participants (including spouses) to submit to a biometric test.[32] Failure to do so resulted in denial of a $250-$1,500 Health Savings Account contribution, a $500 surcharge and a $1,000 tobacco surcharge.[33] Honeywell offered three alternatives to the biometric test to avoid the tobacco surcharge: 1) enroll in a tobacco cessation program (actual cessation not required); 2) submit a physician report that indicates that neither the employee nor spouse use tobacco; or 3) work with a health advocate to establish that the employee or spouse is not a tobacco user.[34] Each of these cases is still pending before their respective courts.[35] However, the *Honeywell* court recently dismissed the EEOC's motion for a preliminary injunction to enjoin Honeywell from levying all penalties and costs against any Honeywell employee who refuses to undergo biomedical testing in conjunction with Honeywell's wellness program.[36]

These cases have caused much anxiety in the worksite wellness community because many employers use wellness screening activities such as those described in the cases to help reduce medical costs, absenteeism and

health-related productivity losses.[37] Indeed, according to a RAND study on worksite wellness programs, approximately half of U.S. employers offer wellness promotion initiatives.[38] Of those, 72 percent characterize their wellness program as a combination of screening activities, such as health risk assessments and biometric screens, and interventions.[39]

In all three EEOC cases identified above, the EEOC alleged that the companies' wellness programs violated the Americans with Disabilities Act ("ADA"). The EEOC's position is that the health risk assessment or biometric test constituted an involuntary medical examination that is not job-related.[40] The ADA prohibits employee medical examinations, such as health risk assessments or biometric tests, unless those inquiries are job-related and consistent with business necessity.[41] The ADA provides an exception for medical inquiries that are part of a "voluntary" wellness program.[42]

The EEOC did not view having to pay 100 percent of one's health insurance premium for failing to participate in the wellness program, as was the case in *Orion Energy* and *Flambeau*, to be voluntary. It also did not view the large penalties imposed by Honeywell as promoting a voluntary program. Furthermore, in the *Honeywell* case, the EEOC alleged a violation of the Genetic Information Nondiscrimination Act ("GINA") because the biometric screen offered a financial inducement in exchange for information about the manifestation of disease in employees' spouses, who are considered "family" under GINA.[43] GINA prohibits the offering of any financial inducements to individuals for providing genetic information as part of a wellness program.[44]

Despite the alleged ADA and GINA violations, the wellness programs at each of these employers complied with the Patient Protection and Affordable Care Act's ("PPACA") modifications to the Health Insurance Portability and Accountability Act ("HIPAA") nondiscrimination provisions.[45] Specifically, these programs were "participatory" wellness programs under PPACA/HIPAA, meaning that to obtain the reward, the participant does not have to satisfy a health status factor.[46] Unlike health contingent programs, which do have a limit on the amount of a "reward," participatory programs have no limit on the financial reward that is used to encourage participation.[47] Indeed, the employers in all three cases pointed out that their wellness programs complied with the PPACA/HIPAA nondiscrimination standards.[48] As a result, under the employers' reasoning, the wellness programs are legal and should not be facing EEOC criticism. Moreover, each employer in the EEOC cases argues that, regardless of the legality of their program under PPACA/HIPAA, their wellness programs fit within the voluntary medical examination provision of the ADA.[49] As contended by Honeywell, merely providing a financial incentive to participate in a program does not transform it into an involuntary program.[50]

There is a lesson to be learned in the logic espoused by the employers in the EEOC cases cited above: just because a program can arguably fit within legal parameters does not mean the program will be accepted by those it is intended to help. Some employees from those PPACA/HIPAA-compliant programs pushed back by filing complaints with the EEOC with the hope that the EEOC would rule in their favor and not require them to reveal private information to their employer.[51] Public health agencies and legislators who aim to use their authority under *Jacobson v. Massachusetts* to compel greater vaccination rates may find themselves in a situation similar to the employers in the EEOC cases. Using laws as shoves rather than nudges may increase vaccination rates, but such tactics do not address the underlying beliefs in the anti-vaccination movement. Compulsory vaccination does not educate the population on the science behind why vaccination is important to the health of a whole community. Relying on vaccination laws alone allows the misinformation and misunderstanding about vaccinations to persist. Like the employees who complained in the EEOC lawsuits, those who are forced to participate may perceive the law as violating their right to privacy and choice. Such perceptions do not foster a cooperative, healthy culture or society. Public health organizations may want to look to the wellness community for guidance about this issue.

Adopting Worksite Wellness Program Strategies to Create a Positive Culture

The worksite wellness community has developed a number of best practices in wellness program design. Groups such as the Wellness Council of America ("WELCOA"), Harvard School of Public Health, the CDC and Wellsource[52] have created strategies that cultivate worksite wellness program success.[53] Two common strategies are 1) creating leadership buy-in and 2) diverse teams. For example, the CDC recommends obtaining support from company leadership, unions, employees, and external stakeholders before launching a wellness program.[54] WELCOA's first of seven benchmarks is "Capturing CEO Support."[55] According to these groups, obtaining leadership buy-in is critical to establishing a results-oriented employee wellness program. This is because leaders develop the vision, allocate the resources, set the example and communicate the vision of the wellness program.[56] Without leadership support, worksite wellness programs can quickly fall apart.

The second common strategy advocated by wellness program design groups is creating diverse teams. This

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strategy is WELCOA's second in its series of seven benchmarks for creating a results-oriented wellness program.[57] Using WELCOA's benchmark as an example, which Harvard's School of Public Health and the CDC reference,[58] building cohesive, diverse teams to develop and support the worksite wellness program mitigates the creation of an "us vs. them" environment. WELCOA notes that one of the biggest mistakes organizations make when initiating wellness teams is that they only include executives from the upper echelons of the company.[59] To counter this impression, it is critical to include members from throughout the company who represent a range of health and employment status. Harvard's School of Public Health also notes the importance of collaborating with multiple community stakeholders, such as academia, nonprofits, government, professional organizations, employees, insurance providers, and food distributors when aiming to integrate food and fitness into worksite wellness.[60]

Public health leaders could acknowledge these lessons from the worksite wellness community and apply them to the anti-vaccination movement. To do so, it is important to recognize that a number of anti-vaccine proponents rely on their CAM providers for guidance. For example, recent newspaper articles highlight parents who obtain information from the complementary and alternative medicine community, such as homeopathic, chiropractic, or naturopathic providers, to support their choice not to vaccinate their children.[61] These providers have traditionally been outside "mainstream medicine" because CAM and mainstream medicine have historically competed for patients,[62] have different philosophies on how to treat illness,[63] and are grounded differently; mainstream medicine is grounded in western scientific principles whereas CAM is not.[64]

Regardless of these differences, according to the National Center for Complementary and Integrative Health, a division of the National Institutes of Health, nearly 40 percent of Americans use healthcare approaches developed outside mainstream or "Western" medicine,[65] and the use of CAM providers in the United States is growing.[66] One research study notes that women, people with higher education, people who have been hospitalized within the last year, and adults who are former smokers seek CAM at rates higher than the national average.[67] "People seek CAM treatments for a variety of reasons, including to avoid frustrations with the limits of conventional therapies, to seek more autonomy and personal control over health care decisions, and to feed the ethos of self-sufficiency and a rejection of established medical expertise."[68] These reasons for seeking CAM treatment align with a number of the reasons cited earlier regarding opposition to vaccinations.[69] According to one study, children who receive care from naturopathic physicians or chiropractors during the years of their first or second birthdays are significantly less likely to meet the vaccination schedule for MMR, chickenpox or *H. Influenzae* type B than their counterparts.[70] In addition, the study found that pediatric use of naturopathy is associated with significantly more diagnoses of vaccine-preventable diseases.[71]

Despite evidence of a link between CAM provider use and anti-vaccination beliefs, there is little evidence of collaboration between public health and CAM providers. For example, a November 2014 report regarding successful partnerships in improving community health through hospital-public health collaboration made no mention of a need for these collaborations to include CAM providers.[72] The report's authors acknowledged that to have a sustained impact, these partnerships should reach out and engage a broad range of other community organizations and groups, such as school systems, health plans, the business community and local government.[73] However, missing from this list are CAM providers. Excluding CAM providers from community health collaborations when a growing number of Americans rely on them for healthcare guidance may drive a deeper wedge between CAM providers (and their patients) and mainstream healthcare. As learned from the wellness community, an "us vs. them" environment is not conducive to a successful program. Indeed, the National Prevention Council, created by PPACA, encourages coordination and integration of complementary health strategies into preventive care efforts.[74]

With regard to vaccination efforts specifically, there is evidence that CAM providers would be willing to collaborate with public health efforts to increase vaccination rates. Studies indicate that a majority of CAM practitioners make no explicit recommendations about vaccination, and only a minority actively recommend against vaccination.[75] According to the authors of one study, "many providers may be open to more active support of vaccination in conversations with parents" and therefore enlisting assistance from CAM providers in the United States might be productive.[76]

Research has shown that public health messages emphasizing scientific evidence in favor of vaccines is not very effective in promoting vaccination among parents with anti-vaccine attitudes.[77] In fact, dramatic narratives about measles and images of sick children increased misperceptions about the MMR vaccine.[78] One study found that for parents who are least favorable toward vaccines, there is no intervention that could increase their intent to vaccinate.[79] The study's authors suggested, however, that because parents rate their children's doctor as their

most trusted source of vaccine safety information, future research should explore whether pediatricians would be an especially persuasive source.[80] Moreover, a recent article in *The New Yorker* magazine suggested that the anti-vaccination message cannot change unless the perceived consensus among figures seen as opinion and thought leaders changes first.[81]

Because anti-vaccination supporters may rely on the opinions of their CAM providers, it is important to include those providers in public health collaboration efforts. Involving CAM providers in public health collaborations to improve community health arguably captures the two strategies employed by the wellness community in designing results-oriented wellness programs. First, it is akin to capturing leadership buy-in. CAM providers are often looked to as leaders in natural health and healing, a concept that resonates with many anti-vaccination supporters. Including CAM providers at the table with public health and mainstream medicine providers increases the chance of delivering a more unified message to patients about the value of vaccines. Second, including CAM providers in public health collaborations creates a more diverse, cohesive team to tackle community health issues. Omitting CAM providers from discussions about how to improve vaccination rates leaves out a large and growing sector of health and wellness. Public health organizations aiming to improve vaccination rates may benefit from broadening their definition of healthcare collaborations to include CAM providers. Such inclusion would create a truly diverse, representative team of leaders to tackle community health improvement.

Conclusion

The current measles outbreak serves as a reminder that the United States is a country with diverse opinions that are not always easily swayed by common belief, scientific evidence or what benefits the common good. The tension between individual rights and public health and safety will continue to permeate efforts to improve population health. But, in many circumstances, using only the law to force people to comply with broader health goals is not the best strategy, as learned by a number of employer wellness programs that have been the subject of recent EEOC lawsuits. Public health organizations may find valuable lessons learned from the worksite wellness community. Studies suggest that engaging leadership and diverse teams of health and wellness professionals, including CAM providers, may have a positive impact on vaccination rates, as well as on other community health improvement efforts.

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Endnotes

1 CDC Health Advisory, U.S. Multi-state Measles Outbreak, December 2014-January 2015 (Jan. 23, 2015), available at http://emergency.cdc.gov/han/han00376.asp. Measles is a highly contagious, acute viral illness that begins with fever, cough, runny nose and pink eye lasting two to four days prior to a rash onset. Measles can cause severe health complications, including pneumonia, encephalitis, and death. *Id.* Measles is transmitted by contact with an infected person through coughing and sneezing; infected people are contagious from four days before their rash starts through four days afterwards. *Id.* After an infected person leaves a location, the virus remains viable for up to two hours on surfaces and in the air. *Id.*

2 *Id.*

3 *Id.*

4 Clyde Haberman, *A Discredited Vaccine Study's Continuing Impact on Public Health*, THE NEW YORK TIMES (Feb. 1, 2015), *available at* http://nytimes.com/2015/02/02/us/a-discredited-vaccine-studys-continuing-impact-on-public-health.html?_r=0. Some people should not receive the MMR vaccine, such as those persons with certain allergies, illnesses, or pregnant women, for example. *See* CDC, Who should not get vaccinated with these vaccines?, available at http://cdc.gov/vaccines/vpd-vac/should-not-vacc.htm#mmr.

5 Clyde Haberman, *A Discredited Vaccine Study's Continuing Impact on Public Health*, THE NEW YORK TIMES (Feb. 1, 2015), *available at* http://nytimes.com/2015/02/02/us/a-discredited-vaccine-studys-continuing-impact-on-public-health.html?_r=0.

6 Betsy McKay, *U.S. Measles Cases for 2015 Rise 18.6% Over Past Week*, THE WALL STREET JOURNAL (Feb. 9, 2015).

7 *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 26 (1905).

8 *Id.* at 25 (internal quotations omitted).

9 *Id.* at 26-29.

10 *Id.* at 35.

11 *Id.* (noting that there is scarcely any belief that is accepted by everyone).

12 Clyde Haberman, *A Discredited Vaccine Study's Continuing Impact on Public Health*, THE NEW YORK TIMES (Feb. 1, 2015), *available at* http://nytimes.com/2015/02/02/us/a-discredited-vaccine-studys-continuing-impact-on-public-health.html?_r=0.

13 *Id.*

14 *Id.*

15 *Id.*

16 *Id*; *see also* Sheila Kumar, *Oregon Considers Ban on Most Vaccine Exemptions*, WISCONSIN STATE JOURNAL, at A9 (March 1, 2015).

17 Sheila Kumar, *Oregon Considers Ban on Most Vaccine Exemptions*, WISCONSIN STATE JOURNAL, at A9 (March 1, 2015) (noting that Mississippi and West Virginia are the only states allowing exemptions solely for medical reasons and no longer for personal, religious, or philosophical exemptions).

18 *Id*; *see also* Clyde Haberman, *A Discredited Vaccine Study's Continuing Impact on Public Health*, THE NEW YORK TIMES (Feb. 1, 2015), *available at* http://nytimes.com/2015/02/02/us/a-discredited-vaccine-studys-continuing-impact-on-public-health.html?_r=0 (noting that often these communities have residents who are well off and well educated); Anna Edney, et al., *States Target Anti-Vaccine Parents Amid Measles Outbreak*, BLOOMBERG NEWS (Feb. 6, 2015) (noting a greater level of exemptions since the 1980s).

19 Centers for Disease Control Health Advisory, *available at* http://emergency.cdc.gov/han/han00376.asp.

20 Centers for Disease Control Multi-State Measles Outbreak December 28, 2014 to February 20, 2015, *available at* http://cdc.gov/measles/multi-state-outbreak.html.

21 Anna Edney, et al., *States Target Anti-Vaccine Parents Amid Measles Outbreak*, Bloomberg

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News (Feb. 6, 2015); Natalie Villacorta and Nirvi Shah, Vaccination Foes on the Defensive, Politico (Feb. 2, 2015).

22 Sheila Kumar, *supra,* note 17.

23 *Id; see also* Michigan Register, at 166 (Nov. 1, 2014) available at http://michigan.gov/documents/lara/MR19_110114_473058_7.pdf.

24 Natalie Villacorta and Nirvi Shah, Vaccination Foes on the Defensive, Politico (Feb. 2, 2015).

25 National Public Radio Interview with Dr. Saad Omer of Emory Vaccine Center in Atlanta (Feb. 10, 2015).

26 *Id.*

27 *EEOC v. Orion Energy Systems*, Case No. 2:14-cv-1019 (E.D. Wis. 2014), Complaint, ¶ 10.

28 *Id.* at ¶ 11.

29 *Id.* at ¶ 16.

30 *EEOC v. Flambeau, Inc.*, 3:14-cv-638 (W.D. Wis. 2014), Complaint, ¶¶ 10-11.

31 *Id.* at ¶ 16.

32 *EEOC v. Honeywell, Inc.*, 2014 WL 5795481, * 1 (D. Minn. 2014).

33 *Id.* at * 1-2. It should be noted that the $500 surcharge was not levied against employees whose spouses refused to undergo the biometric test.

34 *Id; see also EEOC v. Honeywell, Inc.*, Case No. 14-CV-04517, Memorandum of Law in Opposition to Plaintiff's Motion for Temporary Restraining Order and Expedited Preliminary Injunction, dkt. #20, at 11 (D. Minn. Oct. 30, 2014).

35 *See* https://pacer.gov/psco/cgi-bin/links.pl.

36 *EEOC v. Honeywell, Inc.*, 2014 WL 5795481, * 1 (D. Minn. 2014).

37 Soeren Mattke, et al., RAND Health, *Workplace Wellness Programs Study, Final Report*, at xix (2013).

38 *Id.* at xiv.

39 *Id.*

40 *See e.g., Honeywell*, 2014 WL 5795481, at * 4.

41 *Id.* (citing 42 USC § 12112(d)(4)(A)) ("A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity").

42 42 U.S.C. § 12112(d)(4)(B); *see also* EEOC Enforcement Guidance: Disability-related Inquiries and Medical Examinations of Employers under the Americans with Disabilities Act Q. 22 (2000) ("A wellness program is 'voluntary' as long as an employer neither requires participation nor penalizes employees who do not participate").

43 *Honeywell*, 2014 WL 5795481, * 5; *see also EEOC v. Honeywell, Inc.*, Case No. 14-CV-04517, Memorandum In Support of EEOC's Application for Temporary Restraining Order and an Expedited Preliminary Injunction, dkt. #4, at 19-26 (D. Minn. Oct. 30, 2014).

44 29 C.F.R. § 1635.8(b)(2)(ii).

45 Public Health Service Act § 2705.

46 42 U.S.C. § 300gg-4(j)(1)(B).

47 42 U.S.C. § 300gg-4(j)(1)(B); 42 USC § 300gg-j(3) (limiting the "reward" to no more than 30% of the cost of health coverage under the plan and defining "reward" to include a discount, rebate, waiver of cost-sharing, absence of surcharge or value of a benefit that would otherwise not be provided under the plan); see also 42 C.F.R. § 146.121(f)(5) (allowing up to 50% of cost of coverage reward for tobacco prevention programs).

48 *See e.g., Honeywell*, 2014 WL 5795481, * 5 (noting Honeywell's argument that "Congress would not expressly endorse in one federal statute what is illegal under another pre-existing federal statute.").

49 *EEOC v. Orion Energy Systems*, Case No. 2:14-cv-1019 (E.D. Wis. 2014), Answer, at 5, ¶ 6; *EEOC v. Flambeau, Inc.*, 3:14-cv-638 (W.D. Wis. 2014), Answer, at 5 ¶ 4; *EEOC v. Honeywell, Inc.*, Case No. 14-CV-04517, Memorandum of Law in Opposition to Plaintiff's Motion for Temporary Restraining Order and Expedited Preliminary Injunction, dkt. #20, at 28 (D. Minn. Oct. 30, 2014).

50 *EEOC v. Honeywell, Inc.*, Case No. 14-CV-04517, Memorandum of Law in Opposition to Plaintiff's Motion for Temporary Restraining Order and Expedited Preliminary Injunction, dkt. #20, at 28 (D. Minn. Oct. 30, 2014) (stating that Honeywell employees are not subject to any discipline or loss of coverage for electing not to participate in biometric screening).

51 *See e.g., EEOC v. Honeywell, Inc.*, Case No. 14-CV-04517, Memorandum In Support of EEOC's Application for Temporary Restraining Order and an Expedited Preliminary Injunction, dkt. #4, at 3, 23 (D. Minn. Oct. 30, 2014).

52 According to its website, Wellsource is a corporate wellness company that specializes in health risk assessment tools and corporate wellness software. *See* http://wellsource.com/home.html.

53 *See e.g.,* WELCOA's Seven Benchmarks available at https://welcoa.org/services/build/welcoas-seven-benchmarks/; Harvard School of Public Health, Adding Food and Fitness to Worksite Wellness, available at http://hsph.harvard.edu/obesity-prevention-source/obesity-prevention/worksites/worksite-wellness-programs-and-obesity-prevention; CDC Healthier Worksite Initiative, available at http://cdc.gov/nccdphp/dnpao/hwi/index.htm; Wellsource Worksite Wellness Program Best Practices, available at http://wellsource.com/articles-mhc/Worksite-Wellness-Program-Best-Practices.html.

54 CDC Healthier Worksite Initiative, Planning 101, available at http://cdc.gov/nccdphp/dnpao/hwi/programdesign/planning101.htm.

55 WELCOA Absolute Advantage, Capturing CEO Support, available at https://welcoa.org/wp/wp-content/uploads/2014/06/01ceosupport.pdf.

56 *Id.* at 10-13.

57 WELCOA's Seven Benchmarks, available at https://welcoa.org/services/build/welcoas-seven-benchmarks.

58 See CDC Healthier Worksite Initiative, Planning Resources, available at http://cdc.gov/nccdphp/dnpao/hwi/programdesign/planning_resources.htm (citing Wellness Council of America as a resource for developing worksite health programs); Harvard School of Public Health, Adding Food and Fitness to Worksite Wellness, available at http://hsph.harvard.edu/obesity-prevention-source/obesity-prevention/worksites/worksite-wellness-programs-and-obesity-prevention (citing Wellness Council of America 7 Benchmarks series for developing results-oriented wellness programs).

59 WELCOA Absolute Advantage, Creating Cohesive Wellness Teams, at 10, available at https://welcoa.org/wp/wp-content/uploads/2014/06/02teams.pdf.

60 Harvard School of Public Health, Adding Food and Fitness to Worksite Wellness, available at http://hsph.harvard.edu/obesity-prevention-source/obesity-prevention/worksites/worksite-wellness-programs-and-obesity-prevention.

61 *See e.g.,* Terrence McCoy, Amid Measles Outbreak, Anti-Vaccine Doctor Revels in his Notoriety, THE WASHINGTON POST (Jan. 30, 2015), available at http://washingtonpost.com/news/morning-mix/wp/2015/01/30/amid-measles-outbreak-anti-vaccine-doctor-revels-in-his-notoriety; David Wahlberg, Vaccine Exemption Rates at some Madison-area Schools Raise Concern, WISCONSIN STATE JOURNAL (Feb. 8, 2015), available at http://host.madison.com/news/local/health_med_fit/vaccine-exemption-rates-at-some-madison-area-schools-raise-concern/article_1fb11058-124c-5b6d-803a-a19df066e578.html; Nathan Hansen, More than 25% of State Schools at Higher Risk, WISCONSIN STATE JOURNAL, at A6 (Feb. 16, 2015).

62 *See e.g.,* Kathleen Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 AM. J. L. AND MED. 185, 186 (1998) (stating that physicians are the main competitors of alternative providers and that physicians convince legislatures to restrict the scopes of practice of other providers and pressure prosecutors to bring criminal actions against nonphysician providers including acupuncturists, chiropractors, homeopaths, midwives, naprapaths and naturopaths).

63 Glenn Bradford and David Meyers, *The Legal and Regulatory Climate in the State of Missouri for Complementary and Alternative Medicine – Honest Disagreement Among Competent Physicians or Medical McCarthyism?,* 70 UMKS L. Rev., 55, 67 (Fall 2001) (stating that one essential philosophical difference between the alternative medicine practitioners and orthodox physicians is that the former claim to be treating the well-being of the body as a whole as a form of preventive medicine, while the latter more typically focus on and reserve their interventions to documented ongoing disease processes); *see also* Ryan Abbott, *Treating the Health Care Crisis: Complementary and*

Alternative Medicine for PPACA, 14 DEPAUL J. HEALTH CARE L. 35, 98 (Fall 2011) (stating that the most significant barrier to incorporating CAM into mainstream medicine is the fact that most CAM treatments lack scientific evidence of safety and efficacy and that the NEW ENGLAND JOURNAL OF MEDICINE has called for the elimination of the distinction between conventional and alternative medicine because both should be tested rigorously).

64 *See e.g.*, Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. Rev. 83 158 (Spring 1996) (noting that therapies such as homeopathic remedies, acupuncture treatment, massage therapy, body-oriented psychotherapy, herbal treatment, and energy healing are practiced largely by nonphysicians, are individualized and not research driven, typically are not "medical," not expensive, and, for the most part, not subject to proof along conventional scientific lines).

65 National Center for Complementary and Integrative Health, Complementary, Alternative or Integrative Health: What's in a Name?, available at https://nccih.nih.gov/health/whatiscam.

66 Lois Downey, et al., *Pediatric Vaccination and Vaccine-Preventable Disease Acquisition: Associations with Care by Complementary and Alternative Medicine Providers*, NIH Public Access, at 3 (2011), available at http://ncbi.nlm.nih.gov/pmc/articles/PMC2924961.

67 Robert Vlasis, *The Doctor is ●ut, or Unconventional Methods for Healing: Resolving the Standard of Care for an Alternative Medicine Practitioner*, 43 Hous. L. Rev., 495, 503 (Symposium, 2006).

68 *Id.* at 503.

69 *See supra* note 16 and accompanying text.

70 Lois Downey, et al., *Pediatric Vaccination and Vaccine-Preventable Disease Acquisition: Associations with Care by Complementary and Alternative Medicine Providers*, NIH Public Access, at 6 (2011), available at http://ncbi.nlm.nih.gov/pmc/articles/PMC2924961.

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73 *Id.* at 39.

74 National Prevention Council, National Prevention Strategy, at 6, 20 (June 2011).

75 Lois Downey, et al., *Pediatric Vaccination and Vaccine-Preventable Disease Acquisition: Associations with Care by Complementary and Alternative Medicine Providers*, NIH Public Access, at 8 (2011), available at http://ncbi.nlm.nih.gov/pmc/articles/PMC2924961.

76 *Id.*

77 Brendan Nyhan, et al, *Effective Messages in Vaccine Promotion: A Randomized Trial*, published online in Pediatrics (March 3, 2014), available at http://dartmouth.edu/~nyhan/vaccine-misinformation.pdf, at 13-14.

78 *Id.* at 14.

79 *Id.*

80 *Id.* at 15.

81 Maria Konnikova, *I Don't Want to be Right*, THE NEW YORKER MAGAZINE (May 16, 2014), available at http://newyorker.com/science/maria-konnikova/i-dont-want-to-be-right.