

No. 25-2159

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

TRACY A. WILLIAMS,
Plaintiff-Appellant,

v.

BALLY'S MANAGEMENT GROUP, LLC,
Defendant-Appellee.

On Appeal from the United States District Court
for the District of Rhode Island
Case No. 1:25-cv-00147 (McElroy, D.J.)

**BRIEF OF THE CHAMBER OF COMMERCE OF THE
UNITED STATES OF AMERICA AS AMICUS CURIAE IN SUPPORT OF
APPELLEE AND AFFIRMANCE**

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CORPORATE DISCLOSURE STATEMENT

The Chamber of Commerce of the United States of America is a non-profit, tax-exempt organization incorporated in the District of Columbia. The Chamber has no parent corporation, and no company has 10% or great ownership in the Chamber.

Dated: April 1, 2026

s/ Jaime A. Santos
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INTEREST OF AMICUS CURIAE

The Chamber of Commerce of the United States of America (Chamber) is the world's largest business federation.¹ The Chamber represents approximately 300,000 direct members and indirectly represents the interests of more than three million businesses and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent its members' interests in matters before the courts, Congress, and the Executive Branch. To that end, the Chamber regularly participates as amicus curiae in this Court and in others in cases that raise issues of concern to the business community. *See, e.g., Barchock v. CVS Health Corp.*, 886 F.3d 43 (1st Cir. 2018); *United States v. Regeneron Pharms., Inc.*, 128 F.4th 324 (1st Cir. 2025).

The Chamber has a strong interest in the outcome of this litigation because many of the Chamber's members sponsor benefit plans regulated by the Employee Retirement Income Security Act (ERISA), and many of those plans include wellness programs that help participants by encouraging healthy practices that reduce healthcare costs for plans as a whole. The Chamber files this brief to provide the Court with greater context regarding wellness programs and the flexibility that

¹ All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2). No counsel for a party authored this brief in whole or in part. No party, no counsel for a party, and no person other than amicus, its members, and its counsel made a monetary contribution to fund the preparation or submission of this brief.

ERISA affords plan sponsors in deciding whether to include wellness programs and how to structure those programs.

INTRODUCTION

Congress pursued an important goal in authorizing health plan sponsors to implement employee wellness programs in both the Health Insurance Portability and Accountability Act of 1996 (HIPAA)² and the Patient Protection and Affordable Care Act (ACA).³ As discussed in a detailed report sponsored by the Department of Health and Human Services (HHS) and the Department of Labor (DOL) as required by the Affordable Care Act, wellness programs encourage individuals to make healthy lifestyle choices and to take preventive measures that result in long term health benefits. *See* Soeren Mattke et al., Rand Health, *Workplace Wellness Programs Study: Final Report* xiii, 1-2 (2013) (*RAND Report*).⁴ Those individual choices lead to significant cost savings for employer-sponsored health plans and can potentially lower health costs system-wide. *Id.* at xix, xxvi, 53-65.

This virtuous cycle is exactly what Congress wanted to enable and encourage when it enacted the Affordable Care Act, which contains numerous provisions “intended to contain health care cost growth and expand health promotion and

² Pub. L. No. 104-191, § 101, 110 Stat. 1936.

³ Pub. L. No. 111-148, § 2705, 124 Stat. 119 (2010).

⁴ https://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf.

prevention activities.” *RAND Report* 3. By contrast, unhealthy lifestyle choices (such as inactivity and poor nutrition) increase the prevalence of chronic disease, such as diabetes, heart disease, and chronic pulmonary conditions—conditions that “lead to decreased quality of life, premature death and disability, and increased health care cost,” along with loss of productivity and absenteeism, all of which Congress understandably wanted to avoid as much as possible. *Id.* at 3; *see id.* at xiii.

Congress chose to enable healthy lifestyle choices by allowing employers that sponsor health plans to incorporate wellness programs into those health plans and by affording plan sponsors wide flexibility to design those plans. Wellness programs can and do take many forms, including programs related to nutrition, weight loss, tobacco cessation, fitness, alcohol and drug abuse, stress management, and health education. *RAND Report* xv. The incentives offered by these wellness programs are also highly varied, ranging from cash rewards to health premium surcharges or discounts, gift cards, novelty items (like t-shirts), or discounted gym memberships. *Id.* at vxiii.

Wellness programs provide “statistically significant and clinically meaningful” health improvements in many cases. *Rand Report* xvii. For health plans in particular, the data show meaningfully positive results. A 2010 meta-analysis indicates that for every dollar spent, there was a \$3 average return in

reducing health care costs and absenteeism. Katherine Baicker et al., *Workplace Wellness Programs Can Generate Savings*, 29 Health Aff. 304, 304-311 (2010).⁵

As health services and medications have gotten more expensive over time, healthy lifestyle choices have become one of the most important ways to contain healthcare costs. But there is no single tried-and-true method of encouraging people to make healthy choices. Accordingly, in expressly authorizing employers to adopt wellness programs as part of their employer-sponsored health plans, Congress imbued employers with the flexibility and leeway to implement different types and structures of wellness programs to encourage maximizing employees' adoption of healthy living habits. Flexibility and innovation are crucial to achieving Congress's goals because there is still much that employers and healthcare providers can learn about what effectively incentivizes and promotes healthy lifestyles and outcomes.

The flexibility and innovation Congress provided to employers is at risk of being eviscerated. Through muddled and contradictory regulations and sub-regulatory guidance, combined with a recent flood of private-plaintiff lawsuits seeking an aggressive and overly restrictive interpretation of ERISA's wellness-program provisions, the flexible system Congress created and encouraged employers to adopt has been distorted and weaponized through fiduciary-breach litigation in a

⁵ http://publichealth.lacounty.gov/diabetes/docs/National_DPP_Research_Articles/Baicker_Workplace_Wellness_Programs_Can_Generate_Savings_2010.pdf.

way that Congress could never have imagined. Wellness programs are intended to be laboratories of innovation, not litigation traps. This Court should reject Plaintiff’s constrained view of ERISA’s wellness provisions and embrace the flexible approach adopted by the district court—and, more importantly, by Congress.

ARGUMENT

I. The history of wellness programs is a classic case of congressional flexibility followed almost immediately by agency overreach.

For three decades, ERISA has expressly permitted employers to offer premium discounts to employees who engage in healthy lifestyle practices (or refrain from unhealthy practices) or participate in programs designed to promote health. As DOL has explained, numerous articles and studies have found a “statistically significant” positive impact on healthy lifestyle choices from workplace wellness programs, which results in “health care savings, reduced absenteeism, and [improved] employee satisfaction.” Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33158, 33170 (June 3, 2013) (codified at 29 C.F.R. § 2590.702) (the “2013 Regulation”).

A. Wellness programs were expressly authorized by Congress through HIPAA, 110 Stat. at 1945-1946. HIPAA amended ERISA to prohibit discrimination based on health status by forbidding any participant or beneficiary from “pay[ing] a premium or contribution which is greater than such premium or contribution for a similarly situated” individual or dependent “on the basis of any health status-related

factor.” 29 U.S.C. § 1182(b)(1).⁶ Congress made clear, however, that “programs of health promotion and disease prevention” (known as wellness programs) are not considered discrimination based on health status-related factors. 29 U.S.C. § 1182(b)(2). Specifically, HIPAA’s amendments to ERISA state that the anti-discrimination provision shall not “be construed” to “prevent a group health plan” from “establishing premium discounts or rebates ... in return for adherence to” a wellness program. *Id.*

While HIPAA amended ERISA to expressly authorize “programs of health promotion and disease prevention” and made clear that these types of programs are *not* considered a form of discrimination on the basis of a health status-related factor, the statute was light on the details of what “programs of health promotion and disease prevention” could or should look like. Instead, Congress instructed the agencies with authority over employer-sponsored health plans to “promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part.” 110 Stat. at 1951. Accordingly, HHS, DOL, and the Department of the Treasury promulgated interim and then final regulations filling in the statutory gaps. *See Nondiscrimination and Wellness Programs in Health Coverage in the Group Market*, 71 Fed. Reg. 75014 (Dec. 13, 2006) (the “2006 Regulation”).

⁶ ERISA defines the health status-related factors as: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. 29 U.S.C. § 1182(a)(1).

The 2006 Regulation imposed various requirements on wellness programs that conditioned rewards “on satisfaction of a standard related to a health factor.” 71 Fed. Reg. at 75027. To start, the 2006 Regulation imposed limits on the monetary size of the reward, required programs to be reasonably designed, and prescribed that individuals have the opportunity to qualify for the reward at least once per year. *Id.* at 75036. HHS, DOL, and Treasury made clear that these requirements were intended to afford employers with maximum flexibility, and they were “intended to allow experimentation in diverse ways of promoting wellness.” *Id.* at 75018.

Moreover, the 2006 Regulation was expressly intended to create “an easy standard to satisfy,” as long as “a program has a reasonable chance of improving the health of participants and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.” *Id.* at 75018. Employers were not, for example, required to develop “a scientific record” establishing that the chosen wellness program *would clearly work*; by way of example, the agencies explained that employers were even permitted to experiment with holistic wellness components, like “providing rewards to individuals who participated in a course of aromatherapy.” *Id.* The 2006 Regulation described a number of other wellness programs that could qualify, as well including programs relating to participants’

cholesterol level, body mass index (BMI) level, participation in an exercise program, and tobacco-cessation programs. *Id.* at 75028, 75036, 75037.

The 2006 Regulation also required that if a wellness program required an employee to *satisfy* a particular standard (like having a BMI between 19 and 26, or a cholesterol level below 200), then the employer “must provide a reasonable alternative standard for obtaining the reward for certain individuals.” 71 Fed. Reg. at 75019; *see id.* at 75036. But it required a reasonable alternative *only* for participants for whom “it is unreasonably difficult due to a medical condition” or “medically inadvisable to attempt to satisfy” the otherwise applicable standard for obtaining an award. *Id.* at 75036. Thus, for example, if an employer adopted a wellness program that provided rewards to employees with a BMI of between 19 and 26, but achieving that BMI level is “unreasonably difficult due to a medical condition” or “medically inadvisable” for a particular employee (because, for example, the employee is diabetic, has a history of disordered eating, or is extremely overweight), the employer might offer that employee the alternative of “walk[ing] 20 minutes three days a week” to obtain the same reward. *Id.* at 75037. Notably, that reasonable alternative standard is not triggered until the “participant informs the plan that it is unreasonably difficult” or “medically inadvisable” to meet the otherwise applicable standard. *Id.* at 75019. Thus, the agencies made clear, “it might

be possible for some plans to go for years without needing to make available an alternative standard.” *Id.* at 75029.

B. In 2010, Congress ratified the 2006 Regulation by incorporating it into ERISA nearly verbatim. The Affordable Care Act amended ERISA (and the Public Health Service Act (PHSA)) with respect to wellness programs. *See* 29 U.S.C. § 1185d(a)(1) (cross-referencing 42 U.S.C. § 300gg-4). Under the ACA’s amendments, if a wellness program imposes any “conditions for obtaining” a “reward” that are “related to a health status factor,” then certain requirements apply. 42 U.S.C. § 300gg-4(j)(1)(C), (3). Wellness programs must, among other things:

- “be reasonably designed to promote health or prevent disease”;
- “give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year”; and
- ensure that the “full reward under the wellness program shall be made available to all similarly situated individuals.”

Id. § 300gg-4(j)(3)(B)-(D).

To satisfy the third requirement, the statute requires the wellness program to provide either a waiver or a “reasonable alternative standard” for those for whom it is “unreasonably difficult due to a medical condition” or “medically inadvisable to attempt to satisfy the otherwise applicable standard”—just like the 2006 Regulation. 42 U.S.C. § 300gg-4(j)(3)(D).

Unlike in 1996, Congress’s amendment of ERISA through the ACA in 2010

included highly detailed requirements that left few gaps to be filled through agency regulations. And where Congress did leave gaps to fill, it noted those gaps expressly. *E.g.*, 42 U.S.C. § 300gg-4(a)(9) (empowering Secretary to determine other “appropriate” health status-related factors); *id.* § 300gg-4(j)(3)(A) (permitting rewards of “up to 50 percent ... if the Secretaries determine that such an increase is appropriate”).

But that did not deter HHS, DOL, and Treasury from going beyond those parameters. In 2013, the agencies promulgated a lengthy new regulation governing employer-sponsored wellness plans. This is where things started to get squirrely. In promulgating that regulation, DOL did not limit itself to filling those specific gaps; instead, it *supplanted* Congress’s view of what constitutes a “program of health promotion and disease prevention” through new or contradictory requirements.

For example, for outcome-based wellness programs—those that require “an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward”—the 2013 Regulation requires a “reasonable alternative standard (or waiver of the otherwise applicable standard)” for *all* plan participants who request one, not just those for whom it is unreasonably difficult or medically inadvisable to meet the initial outcome-based standard. *See* 29 C.F.R. § 2590.702(f)(1)(v); *id.* § 2590.702(f)(4)(iv). That requirement lies in stark contrast with the statute—and

with the 2006 Regulation that the statute incorporated nearly verbatim. *See* 42 U.S.C. § 300gg-4(j)(3)(D); 71 Fed. Reg. at 75036. The final rule did not even *acknowledge* the conflict with the statute, much less attempt to reconcile the (irreconcilable) requirements.

This conflict is no small matter: every wellness-program case ultimately boils down to whether a plan participant was *discriminated against based on health status* in violation of 29 U.S.C. § 1182 (“Prohibiting discrimination against individual[s] ... based on health status”). That is what the wellness-program requirements are all about,⁷ and it is the express basis of all lawsuits challenging wellness programs, including Plaintiff’s here, *see, e.g.*, Opening Br. 11, 21-22, 32-34. ERISA does not prohibit employers from imposing higher premiums for lifestyle factors like riding a motorcycle or keeping exotic and dangerous pets. Instead, it prohibits premiums that discriminate on the basis of “health status.” 29 U.S.C. § 1182. Accordingly, it makes perfect sense that ERISA requires a plaintiff to demonstrate that he incurred higher premiums because “a health status factor makes it unreasonably difficult or medically inadvisable” to comply with a wellness program—*i.e.*, that he was *discriminated against on the basis of health status*. 42 U.S.C. § 300gg-4(j)(3)(D).

Similarly, the statute’s plain text expressly allows plans to seek verification

⁷ *See* 42 U.S.C. § 300gg-4 (“Prohibiting discrimination ... based on health status”); 29 C.F.R. § 2590.702 (similar).

from a physician that a reasonable alternative standard is medically required for a particular participant. *Id.* § 300gg-4(j)(3)(D)(ii). While the proposed regulation retained this statutory protection, Proposed Rule: Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 Fed. Reg. 70620, 70624 (Nov. 26, 2012), the final rule jettisoned it, once again creating a clear conflict with the statute it was purporting to implement, 78 Fed. Reg. at 33165.

The retroactivity requirement that Plaintiff contends is part of the wellness-program regulation is another prime example of post-ACA regulatory overreach. It cannot be fairly disputed that nothing in the 2006 Regulation required employers to give a *full year's* worth of rewards for *part-year* compliance with a wellness program. Indeed, the 2006 Regulation expressly enumerated as “permissible” a reasonable alternative tobacco-cessation program in which person “*F* can avoid the surcharge *for as long as F* participates in [a tobacco cessation] program, regardless of whether *F* stops smoking (as long as *F* continues to be addicted to nicotine).” 71 Fed. Reg. at 75037 (emphasis added). The clear implication: employers had no obligation to provide rewards to employees for the period of time before they satisfy a reasonable alternative wellness program.

Nothing in the plain text of the ACA requires full-year rewards for part-year compliance. The agencies also did not propose a retroactivity requirement in the post-ACA proposed regulation, nor did they include one in the final rule

promulgated in 2013. Instead, under the auspices of a “clarification,” the agencies purported to craft a new requirement in the preamble to the 2013 Regulation: “[I]f a calendar year plan offers a health-contingent wellness program with a premium discount and an individual who qualifies for a reasonable alternative standard satisfies that alternative on April 1, the plan or issuer must provide the premium discounts for January, February, and March to that individual.” 78 Fed. Reg. at 33163. But the agencies identified nothing in the statute itself that supported this purported “clarification.” And following the promulgation of the 2013 Regulation, the agencies immediately backtracked through subregulatory guidance stating that pro-rated rewards or discounts *are* permitted if employees have at least one chance to qualify for a reward under a reasonable alternative standard at the beginning of a plan year. U.S. DOL, HHS, Treasury, *FAQs* 6 (Jan. 9, 2014) (Question 8) (*FAQs*), <https://tinyurl.com/muhnpv45>. Here too, the agencies did not even attempt to connect this interpretation to the text of the statute.

The 2013 Regulation also deviated from the ACA amendments by requiring additional disclosures that do not exist in the statute’s disclosure provision. ERISA (through the PHSA) requires only that plans disclose “in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard).” 42 U.S.C. § 300gg-4(j)(3)(E). This statutory requirement was drawn *verbatim* from the

2006 Regulation, and thus many employers have understandably maintained the same disclosures both before and after the ACA was enacted. *See* 71 Fed. Reg. at 75036. The agencies’ post-ACA *proposed* rule notably just parroted the statutory disclosure language. 77 Fed. Reg. at 70634. But when promulgating the final rule, the agencies took a completely different approach and added a new disclosure requirement that does not appear in the statute and was never proposed to employers for notice and comment—the purported requirement that plan materials include “a statement that recommendations of an individual’s personal physician will be accommodated” in an outcome-based wellness program. 29 C.F.R. § 2590.702(f)(4)(v). Again, the agencies referred to this new requirement as merely a “clarif[ication],” while identifying nothing in *the statute’s* clear disclosure requirement that supported this clarification—or left any statutory gap for the agency to fill with *new* disclosure requirements. 78 Fed. Reg. at 33166.

II. The plaintiffs’ bar ran with the agencies’ overreaching regulation, suing dozens of employers that have tried to encourage healthy lifestyle choices and bring down healthcare costs through wellness programs.

ERISA’s wellness-program provisions functioned fairly well for almost a decade. DOL brought one enforcement action against a plan sponsor that (among other things) required plan participants to successfully cease using certain products altogether to be eligible for a wellness program reward. *Sec’y of Lab. v. Macy’s, Inc.*, 2021 WL 5359769, at *3 (S.D. Ohio Nov. 17, 2021). But plan sponsors were

generally able to implement a wide variety of wellness program options and structures. In the early 2020s, however, the ERISA plaintiffs' bar took the 2013 Regulation and ran with it, filing dozens and dozens of lawsuits in rapid succession (with most cases filed by the same firm that represents Plaintiff here).⁸ Those lawsuits challenge many different wellness program plan structures, but they focus on the theory that if an employer offers a reasonable alternative standard for obtaining an award under an outcome-based program, then the employer *must* provide retroactive benefits going back to the beginning of the plan year no matter when an employee tries to qualify—indeed, even for employees who choose not to even enroll in an alternative program until the end of the plan year.

These lawsuits are striking in several ways. *First*, while the complaints focus primarily on the lack of a “retroactive” reward for plan participants who ultimately satisfy a reasonable alternative standard at some point during the plan year, the lawsuits themselves have typically been filed on behalf of participants who *never even enrolled in* (much less *satisfied*) a reasonable alternative standard. The lawsuits largely have *not* been filed by participants who allege that they satisfied the

⁸ See, e.g., Groom Law Group, *Burning Questions: Employers Should Evaluate Wellness Programs as Tobacco Premium Surcharge Litigation Moves Forward* (Oct. 22, 2025), <https://www.groom.com/resources/burning-questions-employers-should-evaluate-wellness-programs-as-tobacco-premium-surcharge-litigation-moves-forward/>; Encore Fiduciary, “*Tobacco Surcharge*” *Litigation update* (Jan. 7, 2026), <https://encorefiduciary.com/tobacco-surcharge-litigation-update/>.

reasonable alternative standard and were deprived of the retroactive benefits to which they claim an entitlement. Instead, they are generally filed by employees who allege nothing more than that they participated in a health plan that includes a wellness program that they say contains a “reasonable alternative standard” that provides an inadequate award when it is satisfied (which the plaintiffs generally do not allege that they even attempted).⁹ One might reasonably question how a plaintiff who never attempted to satisfy a reasonable alternative standard can claim that he was injured by the standard’s lack of a retroactive benefit. Even if the employer’s wellness program *had provided* a retroactive benefit to those who satisfy a reasonable alternative standard, a plaintiff who never even *enrolled* in the alternative would not have received that benefit. And where a plaintiff’s claimed injury “would continue to exist even if” the challenged program “were cured of all of its alleged infirmities,” then she generally lacks standing to sue. *Johnson v. U.S. Off. of Pers. Mgmt.*, 783 F.3d 655, 662 (7th Cir. 2015) (affirming dismissal for lack of standing); *accord Coal. for Competitive Elec., Dynergy Inc. v. Zibelman*, 906 F.3d 41, 57-58 (2d Cir. 2018). This serious traceability problem warrants judicial attention. The

⁹ See, e.g., JA_005 (Compl. ¶ 8); Mot. to Dismiss 11-20, *Spencer v. Campbell’s Co.*, No 24-cv-9882 (D.N.J. Feb. 22, 2025), Dkt. No. 32-1; Mot. to Dismiss 7-10, *McNeil v. Marriott Int’l, Inc.*, No. 25-cv-2975 (D. Md. Jan 5, 2026), Dkt. No. 38-1; Letter Mot., *Adamberger v. Cascades USA, Inc.*, No. 25-cv-1116 (N.D.N.Y. Mar. 4, 2026); Compl. ¶¶ 12-13, *Leslie v. Rentokil North America, Inc.*, No. 25-cv-1423 (E.D. Penn Mar. 17, 2025), Dkt. No. 1.; Am. Compl. ¶ 9, *Pinckney v. Nordstrom Inc.*, No. 25-cv-1396 (W.D. Wash. Oct. 10, 2025), Dkt. No. 18.

whole point of Article III standing is that if alleged misconduct did not harm *the plaintiff filing the complaint*, then courts cannot offer advisory opinions about whether that alleged misconduct constitutes a statutory violation in the first place. *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021).

Second, for all of the flaws contained in the 2013 Regulation, the agencies that promulgated that regulation recognized (repeatedly) that ERISA’s wellness program provisions and the regulation promulgated after the ACA were not meant to be restrictive or limiting—instead, they “continue to provide plans and issuers flexibility and encourage innovation.” 78 Fed. Reg. at 33162; 77 Fed. Reg. at 70625. For example, the agencies noted that “the final regulations do not prescribe a particular type of alternative standard that must be provided” but rather “permit plan sponsors flexibility to provide any reasonable alternative,” and that employers could feel free to “select alternatives that entail the minimum net costs ... that are possible to achieve offsetting benefits.” 78 Fed. Reg. at 33172; *see also id.* at 33162 (“[P]lans and issuers have flexibility to determine apportionment of the reward among family members, as long as the method is reasonable.”); *id.* at 33163 (“Plans and issuers have flexibility to determine whether to provide the same reasonable alternative standard for an entire class of individuals ... or provide the reasonable alternative standard on an individual-by-individual basis ...”); *id.* (“These final regulations continue to permit plans and issuers flexibility in designing reasonable alternative

standards.”); *id.* at 33173 (“[T]he Departments believe that this final rule contains considerable regulatory flexibility for plans to design wellness programs that suit their needs.”).

The slew of lawsuits filed by counsel for Plaintiff here attempt to gut that flexibility. These lawsuits challenge many different wellness program plan structures, but at bottom, the suits operate under the assumption that there is a single way to correctly structure a wellness program that includes some type of educational component in lieu of meeting an outcome-based standard. According to these suits, the reasonable alternative standard must be available to every single employee irrespective of their medical condition, it must allow employees to qualify for that reasonable alternative standard at any point during the year that they wish, it must provide retroactive benefits going back to the beginning of the plan year even for employees who choose not to attempt to qualify for the reasonable alternative standard until November or December, and every communication from the plan must include a notice of the reward and alternatives for compliance. Moreover, these suits claim that any departure vests *every* employee who did not receive a reward with the right to sue—even if they would not have received a reward under a wellness program that operates *precisely* how plaintiffs in these cases say wellness programs should operate. That is not how the 2013 Regulation is written, and it is certainly not how the *statute* is written. Instead, the statute imbues plan sponsors with

flexibility and discretion to craft programs they think will resonate most with their employees and best encourage their employee population to adopt healthy lifestyle practices, which will improve health outcomes and bring healthcare costs down for everyone. *See* 78 Fed. Reg. at 33172.

Third, while the 2013 Regulation clearly represents overreach by HHS, DOL, and Treasury (by adopting new requirements that are not found in, and in some instances expressly contradict, the statute), these private-party lawsuits take that overreach to an entirely new level. Even the agencies adopt the view that pro-rated rewards are acceptable if employees have an opportunity to qualify for a full plan year worth of rewards (say, by satisfying the reasonable alternative standard before the plan year begins or at the very beginning of the plan year). *See FAQs* 6 (Question 8). But these lawsuits have incredibly taken the position that this subregulatory guidance is lawless and that ERISA itself requires year-round access to year-round refunds even for employees who choose not to enroll in an educational alternative to an outcome-based standard until the plan year is nearly over. *E.g., Chirinian v. Travelers Cos., Inc.*, 2025 WL 2147271, at *7 (D. Minn. July 29, 2025); *Bailey v. Sedgwick Claims Mgmt. Servs. Inc.*, 2025 WL 2779899, at *10 (W.D. Tenn. Sept. 26, 2025); *Noel v. Pepsico, Inc.*, 2026 WL 558118, at *12 (S.D.N.Y. Feb. 27, 2026). This approach perhaps best exemplifies the concern raised by scholars regarding “statutory drift and mission creep” when “private enforcers drive law enforcement

efforts in new and democratically unaccountable directions” out of a profit-based pursuit. David Freeman Engstrom, *Agencies as Litigation Gatekeepers*, 123 Yale L.J. 616, 638 (2013).

Fourth, these lawsuits focus on ERISA’s fiduciary obligations, framing their claims as being breaches of ERISA’s fiduciary duties of prudence and loyalty and violations of ERISA’s fiduciary prohibited-transaction provisions.¹⁰ But ERISA’s non-discrimination provision and wellness-program requirements are not part of ERISA’s fiduciary provisions, and the word “fiduciary” cannot be found in 29 U.S.C. § 1182 *or* 42 U.S.C. § 300gg-4. Moreover, the only mention of “fiduciary” in the 2013 Regulation is a reassurance to plan sponsors that compliance with ERISA’s wellness-program provisions has “no effect on other laws” and “is not determinative of compliance with any other provision of ERISA,” including “ERISA’s fiduciary provisions.” 78 Fed. Reg. at 33168 (capitalization altered). Nothing about ERISA’s non-discrimination provision or its wellness-program requirements relate to fiduciary acts—instead, they relate to the health plan structure chosen by a plan sponsor, which is decidedly *not* a fiduciary act. *See Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996); *Hughes Aircraft Co. v. Jacobson*, 525 U.S.

¹⁰ *E.g.*, JA_021-026; Compl. ¶¶ 63-70, *Plesha v. Ascension Health Alliance*, No. 24-cv-1459 (E.D. Mo. Oct. 30, 2024), Dkt. No. 1; Am. Compl. ¶¶ 68-79, *Williams v. Target Corp.*, No. 24-cv-3748 (D. Minn. Sept. 26, 2024), Dkt. No. 34; Compl. ¶¶ 115-135, *Brown v. Huntington Ingalls Indus., Inc.*, No. 26-cv-34 (E.D. Va. Mar. 12, 2026), Dkt. No. 1.

432, 443-444 (1999); *Sec’y of Lab. v. Macy’s, Inc.*, 2022 WL 407238, at *3 (S.D. Ohio Feb. 10, 2022). Accordingly, neither ERISA’s fiduciary obligations nor the common law of trusts should have any role in interpreting these statutory or regulatory provisions.

Fifth, the interpretation of the statutory phrase “full reward” advanced by Plaintiff here and by her counsel in other lawsuits is largely divorced from ERISA’s text. As Defendant’s brief explains, the most straightforward reading of “full reward” is that it ensures that participants who complete a reasonable alternative standard do not receive some fraction of the reward received by those who complete the original standard. In other words, if a wellness program provides a \$100 gift card to a sporting-goods store, those who complete the reasonable alternative standard cannot be given a \$50 gift card. If the reward is a monthly gym membership, those who complete the reasonable alternative standard also receive a monthly gym membership, rather than a 50% discount to the same gym. This straightforward interpretation of “full reward” gives full meaning to each word in the statute by preventing plan sponsors from providing some lesser percentage of a reward than that provided to those who complete the original standard.

Nothing in the statutory phrase “full reward,” however, mandates that the participant who completes the reasonable alternative standard late in the plan year also receive the hypothetical reward gym membership for months that have already

transpired, or rebates of the same monetary value as a gym membership. Wellness programs that incentivize participants to complete the standard relevant to their circumstances early in the plan year are not unreasonable, overly burdensome, or mere subterfuge. *See* 42 U.S.C. § 300gg-4(j)(3)(B). Rather such programs are reasonably designed—perhaps ideally designed—to improve the health of or prevent disease in the participating individual by encouraging participants to enroll in and complete the reasonable alternative standard as early as possible. *Id.*

Plaintiff’s contrary interpretation is heavily reliant on principles of deference to administration agencies—Plaintiff asks the Court to defer to the 2013 Regulation and to DOL’s litigating position in *Secretary of Labor v. Macy’s, Inc.*, No. 1:17-cv-541 (S.D. Ohio). *See* Opening Br. 23-26; *Macy’s*, 2021 WL 5359769, at *15. Neither is entitled to deference. To the contrary, DOL’s attempts to leverage agency power to re-interpret and expand the plain text of the ACA should be given particular scrutiny. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 400 (2024).

The 2013 Regulation purports to impose requirements on wellness programs that exceed the limits of the ACA’s plain text. The 2013 Regulation differs from the ACA amendments in several material ways, as described above—such as by changing the universe of participants who are entitled to a reasonable alternative standard, by trying to sneak in a new retroactivity requirement through the preamble, and by adding disclosure requirements not by invitation of Congress but rather

through agency fiat. *See supra* pp. 10-15. Agency regulations that repeatedly depart from the plain statutory text are *far* from the “best reading” of that statute. *See Loper Bright*, 603 U.S. at 400. And of course, “[i]n the business of statutory interpretation, if it is not the best, it is not permissible.” *Id.*

Plaintiff’s invocation of the preamble to impose a universal retroactivity requirement is particularly misguided. Even putting aside the well-settled principle that agency preambles lack the force of law and do not reflect an agency’s consideration in the same way that the regulatory text does,¹¹ the preamble’s purported retroactivity requirement is untethered to ERISA’s statutory text, which provides no indication that Congress ever contemplated a retroactivity requirement. *See* 42 U.S.C. § 300gg-4(j). The 2006 Regulation (the regulatory precursor to the ACA) did not include such a retroactivity requirement; to the contrary, one of the examples contained in the 2006 Regulation made clear that part-year awards were indeed viewed as “permissible,” *see* 71 Fed. Reg. at 75037, and nothing in the statutory text or the legislative or regulatory history leading to the ACA suggests that Congress ever contemplated a retroactivity requirement.

¹¹ *Wyeth v. Levine*, 555 U.S. 555, 575-576 (2009); *see also Gustavsen v. Alcon Lab’ys, Inc.*, 903 F.3d 1, 13 (1st Cir. 2018) (“[I]t is well-established that a regulatory preamble is incapable of altering regulatory text’s plain meaning.”); *Blanco v. Samuel*, 91 F.4th 1061, 1076 (11th Cir. 2024); *AT&T Corp. v. FCC*, 970 F.3d 344, 350-351 (D.C. Cir. 2020).

Moreover, as the district court recognized, deference to HHS, DOL, and Treasury is particularly inappropriate because the “full reward” language the preamble purports to interpret is “parroted” directly from the statute. *See Gonzales v. Oregon*, 546 U.S. 243, 256-257 (2006); *see also Kisor v. Wilkie*, 588 U.S. 558, 578 n.5 (2019) (“[T]his Court has denied *Auer* deference when an agency interprets a rule that parrots the statutory text.”); *compare* 42 U.S.C. § 300gg-4(j)(3)(D), *with* 29 C.F.R. § 2590.702(f)(4)(iv). “An agency does not acquire special authority to interpret its own words when, instead of using its expertise and experience to formulate a regulation, it has elected merely to paraphrase the statutory language.” *Gonzales*, 546 U.S. at 257; *see also Sun Cap. Partners III, LP v. New England Teamsters & Trucking Indus. Pension Fund*, 724 F.3d 129, 141 (1st Cir. 2013).

Indeed, deferring to DOL’s preamble would “permit the agency, under the guise of interpreting a regulation, to create de facto a new regulation.” *Christensen v. Harris Cty.*, 529 U.S. 576, 588 (2000). There’s a reason why DOL did not include the retroactivity requirement in the 2013 Regulation—it clearly would have violated the principle that a final promulgated rule must be a “logical outgrowth” from the proposed rule that was subject to notice and comment. *Nat. Res. Def. Council, Inc. v. U.S. E.P.A.*, 824 F.2d 1258, 1283 (1st Cir. 1987). This mandate is designed to provide “fair notice” to interested parties so that they have the opportunity to comment on or criticize the proposal. *Long Island Care at Home, Ltd. v. Coke*, 551

U.S. 158, 174 (2007); *see also Nat. Res. Def. Council*, 824 F.2d at 1283. Regulated parties had *no* opportunity to comment on a proposed retroactivity requirement, which was not in the post-ACA proposed regulation and was in fact *contrary* to the pre-ACA 2006 Regulation that the ACA was modeled after. Deferring to an agency interpretation that was included in a preamble precisely because it could not (consistent with the APA) be included in the final rule itself would turn principles of administrative law on their head.

As to Plaintiff's request that this Court defer to DOL's litigating position in *Macy's*: Deference to an agency's litigating position is "entirely inappropriate." *Starbucks Corp. v. McKinney*, 602 U.S. 339, 351 (2024) (citation omitted); *cf. O'Connell v. Shalala*, 79 F.3d 170, 179 (1st Cir. 1996) ("[C]ourts customarily withhold *Chevron* deference from agencies' litigating positions." (collecting cases)). That rule serves an important purpose: Substituting "counsel's discretion for that of the (agency) is incompatible with the orderly functioning of the process of judicial review." *Inv. Co. Inst. v. Camp*, 401 U.S. 617, 628 (1971) (alteration in original). Notably, the *Macy's* court has not yet determined the best meaning of statute after having requested supplemental briefs regarding the impact of *Loper Bright*.

In sum, Plaintiff's argument that "full reward" requires full-year rebates covering portions of the year during which a participant did not complete an available original or reasonable alternative standard finds no purchase in the text or

statutory history of the ACA, nor can Plaintiff fall back on DOL's preamble or litigating position.

III. These wellness-program lawsuits would eviscerate the flexibility Congress afforded to employers and undermine Congress's goal of encouraging healthy lifestyle choices.

In context, it makes perfect sense that wellness-program rewards might only be available on a part-year basis for participants who choose to satisfy a reasonable alternative program partway through the plan year. That properly incentivizes participants to begin and complete the program in a timely manner and thus reap the health benefits for a greater portion of the plan year—even immediately after open enrollment, which typically occurs in the fall before the plan year even begins. In that way, the reward and the health benefit are in perfect sync. Moreover, the statutory and regulatory requirements are designed to ensure that wellness programs are not “subterfuge for discriminating based on a health status factor.” 42 U.S.C. § 300gg-4(j)(3)(B); 29 C.F.R. § 2590.702(f)(4)(iii). At the same time, the requirements are designed to give plans a large measure of “flexibility” in designing programs that will be effective and encourage both “innovation” and the greatest degree of employee participation. 78 Fed. Reg. at 33162, 33163, 33172. But under Plaintiff's theory, under which ERISA mandates that employers provide full-year benefits, employers have *less* flexibility to innovate and craft programs that will best encourage employee participation. An employer that does not want to process

retroactive refunds—a logistical nightmare for large plans, and one that provides weaker incentives for healthy behavior—would have to structure their plan to require satisfaction of the reasonable alternative standard *before* the start of the plan year and cut off any access to a reasonable alternative standard once the plan year begins.

Of course, a plan sponsor *could* structure its plan that way and thereby ensure that the “full reward” is available for the entire plan year. But the statute and regulation give an employer flexibility to decide that it would better encourage positive health outcomes to keep a wellness program open *all year long* and allow employees who decide to pursue a healthier lifestyle midyear to receive a reward immediately upon completion. That type of decision allows employees to engage in healthy lifestyle choices at a time of year that best suits their needs and likely means more wellness benefits year-round. It is not “subterfuge for discrimination based on a health factor”; it is a tailored “innovation” that properly takes advantage of the “flexibility” ERISA affords plan sponsors. 78 Fed. Reg. at 33162. And nothing in the statute or regulation forecloses such an approach.

Plaintiff’s wellness-program challenge would replace the flexibility created by Congress and initially recognized by DOL and replace it with a rigid structure in which *only one* type of wellness program is compliant. That outcome that has no basis in the statutory text and ultimately would benefit no one. Employees would

be left with fewer options for reducing their premium contributions (to the extent employers remain willing to offer wellness programs options at all), and employers would be left with less flexibility to encourage healthy lifestyle programs and bring down healthcare costs systemwide. The only individuals who would conceivably benefit are the lawyers who litigate these lawsuits. The Court should reject Plaintiff's theories and resist that outcome.

CONCLUSION

The district court's decision should be affirmed.

Dated: April 1, 2026

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CERTIFICATE OF COMPLIANCE

I hereby certify that this document complies with the type-volume limitations of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 6,498 words, excluding the parts of the document exempted by Rule 32(f).

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Dated: April 1, 2026

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing brief with the Clerk of the United States Court of Appeals for the First Circuit via the CM/ECF system on this 1st day of April 2026. I certify that all participants in this case are registered ECF users and that service will be accomplished by the CM/ECF system.

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