



AMERICAN BENEFITS

COUNCIL

TESTIMONY OF

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ON BEHALF OF THE

AMERICAN BENEFITS COUNCIL

BEFORE THE

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

REGARDING

WELLNESS PROGRAMS UNDER FEDERAL EQUAL
EMPLOYMENT OPPORTUNITY LAWS

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My name is Tamara M. Simon, and I am the Managing Director of the Knowledge Resource Center at Buck Consultants. I am testifying today on behalf of the American Benefits Council (the “Council”), of which Buck Consultants is a member. The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council’s members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

The Council has asked me to testify on its behalf because of my experience in assisting employers, spanning a wide range of industries, to implement wellness programs. As a compliance consultant, my primary role is to help employers and their legal counsel understand their legal obligations regarding their group health plans and wellness programs. I also work closely with the health and productivity consultants that help our clients to design and operationalize these programs. I hope that my perspective, presented on behalf of the Council, is helpful to you as you consider how to address the treatment of wellness programs under federal equal employment opportunity laws.

At the outset, it is important to recognize that employer sponsors of wellness programs, other stakeholders, and regulators share a common goal – the desire to improve the health of employees and their families while providing important and necessary protections for individuals with disabilities. We believe that employer-sponsored wellness programs provide an effective vehicle for achieving this shared objective. We welcome the opportunity to work with the Equal Employment Opportunity Commission (“Commission”) as well as other stakeholders to develop a regulatory regime that will sufficiently address the concerns of all interested parties.

The primary focus of this testimony is to describe the current state of employer-sponsored wellness programs and how the current legislative and regulatory landscape impacts the design and implementation of those programs. Although we provide relevant details regarding statutory and regulatory provisions applicable to wellness programs, the discussion is not intended to be an exhaustive analysis. Rather, the discussion is intended to provide the necessary context regarding how the current legal landscape presents uncertainties for employers who are grappling with how to design effective wellness programs within the contours of the current regulatory arena.

As we look ahead to 2014, when many core provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (“ACA”) – the landmark health care reform law – become effective, we believe employer-sponsored wellness programs will become even more relevant as employers seek to engage employees in improving health and well-being, regardless of whether they ultimately decide to “pay or play” with respect to offering health insurance coverage.

If there is a single takeaway from this testimony today, it is to clearly articulate to the Commission that the health and wellness of the American workforce is not simply an employer issue. Rather, it is an issue for the entire nation. Creating a regulatory framework by which employers can create nondiscriminatory wellness programs that help support the shared vision of improving health for all citizens is the ultimate goal. We believe strongly that if all stakeholders work together, we can identify a framework that acknowledges the concerns of all parties.

OVERVIEW OF CURRENT STATE OF EMPLOYER SPONSORSHIP OF WELLNESS PROGRAMS

Wellness programs are a significant part of the employer-sponsored health coverage landscape. According to the Kaiser Family Foundation's Employer Health Benefits 2012 Annual Survey, 94% of large companies (with 200 or more workers) and 63% of smaller companies in the United States offered at least one wellness program in 2012.¹

Increased Prevalence and Motivating Factors of Wellness Programs

Employers sponsor wellness programs for a variety of reasons. One of the main objectives is to help control rising costs of health care for the American worker.² According to a survey by Buck Consultants representing 1,356 employer respondents based in 45 countries and employing over 17 million people, 87% of employers in the United States identified health care cost reduction as an extremely important or very important objective of their wellness programs. Although reducing the cost trend of health care is a significant reason, it is by no means the only motivator for employers in adopting and maintaining wellness programs. Employers also sponsor wellness programs with the goal of improving worker productivity by reducing absenteeism due to sickness or disability, and also improving workforce morale and engagement.³ In fact, 77% of U.S. employers identified reducing employee absences due to sickness or disability as an extremely important or very important objective of wellness programs.⁴

Effectiveness of Employer-Sponsored Wellness Programs

Both employers and employees agree that wellness programs have been effective in helping to meet the motivating factors and objectives noted above. According to a Kaiser Family Foundation survey, 73% of employers that offer wellness programs think

¹ KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS 2012 ANNUAL SURVEY – WELLNESS PROGRAMS AND HEALTH RISK ASSESSMENTS 178 (2012) [hereinafter KFF SURVEY].

² BUCK CONSULTANTS, WORKING WELL : A GLOBAL SURVEY OF HEALTH PROMOTION AND WORKPLACE WELLNESS STRATEGIES, SURVEY REPORT 12 (2012) [hereinafter BUCK CONSULTANTS SURVEY].

³ *Id.* at 12.

⁴ BUCK CONSULTANTS SURVEY, *supra* note 2, at 16.

offering such programs is effective in improving their employees' health,⁵ and 52% of employers think offering wellness programs is effective in reducing their health care costs.⁶ The survey by Buck Consultants confirms that wellness programs are beneficial to both employers and employees. Although outcome measurement of wellness programs can be challenging for a variety of reasons (*e.g.*, lack of resources and measurement know-how), among organizations with wellness programs in effect for five years or more, 84% reported a medium to high impact in reduction of population health risks, and 88% reported a medium to high impact on improved workforce morale and engagement.⁷ Wellness programs are popular with employees as well. One study found that over 90% of employees surveyed who have utilized any aspect of their company's wellness program say they are likely or very likely to continue to do so in the future. Approximately two-thirds of employees say that their company's wellness program has helped them to reach one or more of their personal fitness goals.⁸

While there is limited data on the extent to which wellness programs deliver reduced costs for employers, a recent RAND study found that historical data suggests a return on investment ranging from \$6 for every \$1 dollar spent, to, at a minimum, cost neutrality.⁹ Perhaps most significantly, the RAND study reported that most employers are not measuring return on investment with respect to their wellness programs.¹⁰ As noted above, based on discussions with Council members, it appears that employers are generally taking a more long-term and holistic view in measuring the potential benefits associated with the establishment and sponsorship of a wellness program, including in terms of increased employee productivity and morale, and reduced absenteeism and presenteeism.

Program Designs Vary

Employers have developed a variety of wellness program designs. The most common offerings generally include biometric screening programs (for blood pressure, cholesterol, glucose, and body fat), immunizations/flu shots, health risk appraisals, and employee assistance programs ("EAPs").¹¹ Many employers also reward participants for using certain tools that are designed to increase employees' awareness of their current health, such as health risk assessments ("HRAs") and various diagnostic tests or screenings, such as those regarding cholesterol levels and blood pressure.¹²

⁵ KFF SURVEY, *supra* note 1, at 179.

⁶ *Id.* at 179.

⁷ BUCK CONSULTANTS SURVEY, *supra* note 2, at 51-52.

⁸ SHAPEUP, INC., 2012 EMPLOYEE SURVEY ON CORPORATE WELLNESS PROGRAMS 21, 24 (2012).

⁹ RAND HEALTH, A REVIEW OF THE U.S. WORKPLACE WELLNESS MARKET 27 (2012).

¹⁰ *See id.* at 27.

¹¹ BUCK CONSULTANTS SURVEY, *supra* note 2, at 21-30.

¹² AON HEWITT, 2012 HEALTH CARE SURVEY 10 (2012).

Participation Expansion and Global Prevalence

The success of wellness initiatives has led employers to expand these programs to the family members of their employees with increasing frequency, as well.¹³ The Kaiser Family Foundation survey found that 60% of firms offering wellness benefits to employees now also offer wellness benefits to spouses and/or dependents.¹⁴ Among participating employers, wellness programs are most widespread in North America, with 76% of employers offering a health promotion program of some kind. However, employer-sponsored wellness is not only a domestic trend. For instance, 47% of employers in Asia offer health promotion programs, 43% in Latin America, and 42% in Europe.¹⁵ Prevalence variations are likely due, in part, to the different health care systems found throughout the world.

Rewards and Incentives

Some wellness program designs include a reward or incentive element generally attempting to encourage participation in wellness programs, to increase overall participation, and to encourage employees to strive for healthy results. According to the Wall Street Journal, “Studies have shown that [wellness] program participation rates can be pushed from 40% without an incentive to more than 70% with a \$200 incentive and to 90% when incentives are built into health-plan premiums or deductibles.”¹⁶

Data indicates that positive reinforcement or “carrots” are more likely to be used than penalties or “sticks” in connection with wellness programs. For example, according to the Buck Consultants survey, 66% of employers in the United States offer rewards to encourage participation in wellness programs, 21% offer both rewards and penalties, and a mere 2% offer only penalties.¹⁷

While incentives can be tied to participation, wellness programs may also be designed to link receipt of the incentive to the achievement of a specific health outcome. For example, a recent survey by Aon Hewitt found that 58% of employers offer incentives for completion of a lifestyle modification program (*e.g.*, participating in a smoking cessation or weight loss program), and approximately 25% offer incentives for progress toward or attainment of a specified health goal (*e.g.*, improved blood pressure, BMI, blood sugar or cholesterol).¹⁸

¹³ BUCK CONSULTANTS SURVEY, *supra* note 2, at 33.

¹⁴ KFF SURVEY, *supra* note 1, at 178.

¹⁵ BUCK CONSULTANTS SURVEY, *supra* note 2, at 8.

¹⁶ Michael P. O'Donnell, *Should Employees Get Insurance Discounts for Completing Wellness Programs?*, WALL ST. J., Feb. 18, 2013, at R5.

¹⁷ BUCK CONSULTANTS SURVEY, *supra* note 2, at 35.

¹⁸ AON HEWITT, 2012 HEALTH CARE SURVEY 35 (2012).

Employer surveys indicate that incentives most frequently take the form of cash or merchandise awards.¹⁹ Alternatively, some employers offer group health plan premium rebates or surcharges or provide for additional employer contributions to medical savings accounts, such as employer flex credit contributions to health flexible spending arrangements or employer contributions to Health Savings Accounts or health reimbursement arrangements. In 2011, the percentage of employers using monetary incentives increased by 22% (from 37% in 2010 to 59% in 2011).²⁰

LEGAL LANDSCAPE

Wellness programs are subject to the jurisdiction of the Department of Labor (“DOL”), the Department of the Treasury (“Treasury”), the Department of Health and Human Services (“HHS”), and the Commission via a range of federal statutes and regulations. Many states have laws governing wellness programs, as well. The discussion below sets forth the basic federal legal framework applicable to the oversight of wellness programs. As noted above, this is not intended to be an exhaustive discussion of all federal legal issues related to wellness programs but rather to provide a basis for understanding compliance and other issues employers face with regard to wellness programs.

Health Insurance Portability and Accountability Act of 1996

For years, wellness programs have been subject to extensive regulation by the DOL, HHS, and Treasury by virtue of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (“HIPAA”). HIPAA provides privacy and nondiscrimination protections to consumers in connection with group health plans.

Specifically, Titles I and IV of HIPAA added certain provisions to the Internal Revenue Code (“Code”), the Employee Retirement Income Security Act (“ERISA”), and the Public Health Service Act (“PHSA”).²¹ These provisions are generally intended to prohibit group health plans and group health insurance issuers from discriminating against individuals in eligibility, benefits, or premiums based on a health factor, which includes, among other things, disability.²² An exception to the general rule allows premium discounts, rebates, and cost-sharing modifications (all forms of incentives or

¹⁹ BUCK CONSULTANTS SURVEY, *supra* note 2, at 38.

²⁰ AON HEWITT, 2012 HEALTH CARE SURVEY 33 (2012).

²¹ See Code § 9802, ERISA § 702, PHSA § 2705.

²² See Code § 9802(a)(1) (“... a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on . . . [d]isability.” Other health factors are (i) health status, (ii) medical condition (including both physical and mental illnesses), (iii) claims experience, (iv) receipt of health care, (v) medical history, (vi) genetic information, and (vii) evidence of insurability (including conditions arising out of acts of domestic violence).

rewards) in return for adherence to certain programs of health promotion and disease prevention, such as a wellness program.²³

Regulatory Provisions and History

Final regulations issued by the DOL, HHS, and Treasury that have been in effect since 2007 impose rules that certain wellness programs must satisfy in order to allow incentives to be provided to participants.²⁴ Programs that either do not require an individual to meet a standard related to a health factor in order to obtain a reward or that do not offer a reward at all (“participatory wellness programs”) are not subject to the additional rules if participation in the program is made available to all similarly situated individuals.²⁵ Programs that require individuals to satisfy certain health factor standards in order to obtain a reward (“health-contingent wellness programs”) must satisfy a host of requirements in order to satisfy the HIPAA nondiscrimination rules.²⁶ Specifically, under current rules, health-contingent wellness programs must satisfy the following five factors:

1. The total reward for all wellness programs offered by a plan sponsor does not exceed 20 percent of the cost of coverage under the plan.
2. The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals, 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.
3. The program must give eligible individuals an opportunity to qualify for the reward at least once per year.
4. The reward is available to all similarly situated individuals. For this purpose, a reasonable alternative standard (or waiver of the otherwise applicable standard) must be made available to any individual for whom it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard during that period (or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard).

²³ Code § 9802(a)(1).

²⁴ Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014 (Dec. 13, 2006).

²⁵ See 26 C.F.R. § 54.9802-1(f)(1). Examples of participatory wellness programs include reimbursement of gym memberships, diagnostic testing that does not condition receipt of reward on attainment of certain outcomes, and a program that reimburses employees for the costs of smoking cessation programs regardless of whether an employee stops smoking.

²⁶ See 26 C.F.R. § 54.9802-1(f)(2). Examples include not smoking, attainment of certain biometric screening results, and achieving exercise targets.

5. In all plan materials describing the terms of the program, the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) is disclosed.²⁷

The above requirements are all intended to prevent discrimination in the use of incentives in connection with wellness programs based on a health factor such as disability. In particular, the requirements that a wellness program (i) “not be a subterfuge for discriminating based on a health factor, and not be highly suspect in method,” and (ii) the requirement that a “reasonable alternative standard (or waiver of the otherwise applicable standard)” be provided to individuals for whom it is unreasonably difficult due to a medical condition to satisfy the standard or for whom it is medically inadvisable to attempt to satisfy the standard each provide stringent protections to individuals with disabilities.

On November 26, 2012, the agencies published in the Federal Register new proposed rules that added new requirements to the existing HIPAA protections. It is our understanding that DOL, HHS, and Treasury are aiming to finalize the new rules in the near term. The final rules are likely to adopt some, and could perhaps include all, of the proposed new changes.

Recent Congressional Support for HIPAA-Compliant Wellness Programs

Congress signaled its strong support for the use of wellness program incentives and the protections provided in the current HIPAA nondiscrimination rules in a bipartisan provision of the ACA. Specifically, ACA section 1201 codifies the HIPAA regulations and increases the permitted incentive from 20% to 30% (and permits regulators to increase incentives up to 50% in their discretion). This is a rare bipartisan provision in the controversial health care reform law, and it reflects Congress’s approval of the offering of incentives for health-contingent wellness programs.

Affordable Care Act

The ACA has helped to cement wellness programs as one of the cornerstones of health reform. In addition to the express codification of the HIPAA wellness program regulations in ACA section 1201 discussed above, there are numerous other provisions relating to wellness initiatives in the ACA, including:

- Authorization of the Patient-Centered Outcomes Research Institute to conduct research to provide information about prevention, treatment, and care options

²⁷ See 26 C.F.R. § 54.9802-1(f)(2).

available to individuals.²⁸

- Employer wellness program evaluation tools.²⁹
- Health plan quality-of-care report and employee notice.³⁰
- Small-employer wellness program grants.³¹

These provisions are inextricably linked to the fundamental fabric of the ACA and indicate the clear intent of Congress and the Obama Administration that wellness programs should be analyzed, studied, and incorporated into the new reformed health care system, and that the employer role in sponsoring wellness plans should be supported.

Genetic Information Nondiscrimination Act of 2008

Wellness program design and implementation is also shaped by the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233 (“GINA”). Title I of GINA, which is under the jurisdiction of DOL, HHS, and Treasury, addresses whether, and to what extent, group health plans may collect or use genetic information, including family medical history. Title II of GINA, under the jurisdiction of the Commission, restricts how employers and certain other “covered entities” (collectively referenced herein as employers for purposes of clarity) may collect and disclose genetic information and prohibits employers from using genetic information in employment decisions.

Title I: Title I of GINA amended the Code, ERISA, and the PHSA to prohibit discrimination in health coverage based on genetic information. Interim final rules were published in the Federal Register on October 7, 2009.³² Title I of GINA, in relevant part, prohibits group health plans and health insurance issuers in the group and individual markets from discriminating against covered individuals based on genetic information. Title I applies to a wide variety of group health plans, including wellness programs that constitute or are related to group health plans. Title I generally prohibits a group health plan and a health insurance issuer in the group market from:

²⁸ ACA § 6301.

²⁹ ACA §§ 4303, 10404.

³⁰ ACA § 1001.

³¹ ACA § 10408.

³² Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. 51,664 (Oct. 7, 2009).

- increasing the group premium or contribution amounts based on genetic information;
- requesting or requiring an individual or family member to undergo a genetic test; and
- requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.³³

The prohibition on requesting, requiring or purchasing genetic information at any time for underwriting purposes affects wellness programs. The term “underwriting purposes” is defined broadly to include rules for eligibility for benefits and the computation of premium or contribution amounts, and it does not merely encompass activities relating to rating and pricing a group policy.³⁴ The regulations clarify that the term “underwriting purposes” includes changing deductibles or other cost-sharing mechanisms, or providing discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing an HRA or participating in a wellness program.³⁵ “Genetic information” is defined for purposes of GINA Title I to include family medical history.³⁶

Wellness programs cannot provide rewards for completing HRAs that request genetic information (including family medical history), because providing rewards would violate the prohibition against requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes. A plan or issuer can collect genetic information through HRAs under Title I of GINA as long as no rewards are provided for such genetic information (and if the request is not made prior to or in connection with enrollment).³⁷ A plan or issuer can provide rewards for completing an HRA as long as the HRA does not collect genetic information.

Title II

Title II of GINA, which is under the Commission’s jurisdiction, restricts how employers may collect and disclose genetic information and prohibits employers from using genetic information in employment decisions. Final regulations under Title II

³³ Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. at 51,665.

³⁴ Code § 9832(d)(10)(B).

³⁵ 26 C.F.R. § 54.9802-3T(d)(1)(ii); 29 C.F.R. § 2590.702-1(d)(1)(ii); 45 C.F.R. § 146.122(d)(1)(ii).

³⁶ 26 C.F.R. § 54.9802-3T(a)(3); 29 C.F.R. § 2590.702-1(a)(3); 45 C.F.R. § 146.122(a)(3).

³⁷ Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. at 51,669.

were published in the Federal Register on November 9, 2010.³⁸

The final Title II regulations provide that it is unlawful for an employer to discriminate against an individual based on his or her genetic information with regard to, among other things, privileges of employment.³⁹ Where a wellness program is considered to be a privilege of employment, the sponsoring employer may be subject to regulation under Title II with respect to the wellness program.

Title II generally prohibits employers from requesting, requiring or purchasing genetic information of an individual or a family member of the individual. An exception is provided where health or genetic services are offered by the employer, including where they are offered as part of a wellness program, if the employer meets certain requirements:

- the provision of genetic information by the individual is voluntary, meaning the covered entity neither requires the individual to provide genetic information nor penalizes those who choose not to provide it;
- the individual provides prior knowing, voluntary, and written authorization, meaning that the covered entity uses an authorization form that (i) is written in language reasonably likely to be understood by the individual from whom the information is sought, (ii) describes the information being requested and the general purposes for which it will be used, and (iii) describes the restrictions on disclosure of genetic information;
- individually identifiable genetic information is provided only to the individual (or family member and the health care professional or genetic counselor providing services); and
- the information cannot be accessed by the employer (except in aggregate terms).⁴⁰

Incentives may not be offered for individuals to provide genetic information.⁴¹ Thus, an employer may offer an incentive for completing an HRA (a common component of wellness programs) that includes questions about family medical history or other genetic information, provided that the employer specifically identifies those questions and makes clear, in language reasonably likely to be understood by those completing

³⁸ Regulations Under the Genetic Information Nondiscrimination Act of 2008, 75 Fed. Reg. 68,912 (Nov. 9, 2010).

³⁹ See 29 C.F.R. § 1635.4.

⁴⁰ 29 C.F.R. §1635.8(b)(i). See also Commission Informal Discussion Letter (June 24, 2011), http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html.

⁴¹ See 29 C.F.R. § 1635.8(b)(2)(ii).

the HRA, that an individual need not answer the questions that request genetic information in order to receive the incentive.

In addition, the final regulations provide that an employer may offer an incentive to encourage individuals who have voluntarily provided genetic information that indicates they are at increased risk of acquiring a health condition in the future to participate in disease management programs or other programs that promote healthy lifestyles, and/or to meet particular health goals as part of a health or genetic service. However, to comply with Title II of GINA, these programs must also be offered to individuals with current health conditions and/or to individuals whose lifestyle choices put them at increased risk of developing a condition but who have not volunteered genetic information.⁴²

Americans with Disabilities Act

The Commission also regulates wellness programs pursuant to Title I of the Americans with Disabilities Act (“ADA”). Title I of the ADA prohibits discrimination against qualified individuals with disabilities.⁴³ The Act prohibits employers from conducting medical examinations or making inquiries regarding disabilities at any point during the hiring process or during employment, with certain limited exceptions.⁴⁴

Title I of the ADA allows employers to conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at a work site. Any medical information acquired as part of the program is kept confidential and separate from personnel records. There is little guidance regarding what the term “voluntary” means in this context.

The Commission has issued numerous informal discussion letters that generally provide that a wellness program is considered voluntary as long as an employer neither requires participation nor penalizes employees who do not participate.⁴⁵ The Commission has stated in certain of these informal discussion letters that it has not

⁴² 29 C.F.R. §1635.8(b)(2)(iii).

⁴³ 42 U.S.C. § 12112(a).

⁴⁴ 42 U.S.C. § 12112(d).

⁴⁵ See Commission Informal Discussion Letter (Jan. 18, 2013), http://www.eeoc.gov/eeoc/foia/letters/2013/ada_wellness_programs.html; Commission Informal Discussion Letter (June 24, 2011), http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html; Commission Informal Discussion Letter (May 6, 2009), http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html. See also AMERICAN BAR ASS’N, QUESTIONS FOR THE EEOC STAFF FOR THE 2009 JOINT COMMITTEE OF EMPLOYEE BENEFITS TECHNICAL SESSION (2009), <http://www.abanet.org/jceb/2009/EEOC2009.pdf>.

taken a position on whether, and to what extent, Title I of the ADA permits an employer to offer financial incentives for employees to participate in wellness programs that include disability-related inquiries (such as questions about current health status asked as part of an HRA) or medical examinations (such as blood pressure and cholesterol screening to determine whether an employee has achieved certain health outcomes). The Commission has also issued Enforcement Guidelines providing, among other things, that a wellness program is voluntary as long as an employer neither requires participation nor penalizes employees who do not participate.⁴⁶

The Commission has, on at least two occasions, come close to providing clarifying guidance. In 1998, the Commission stated in an informal discussion letter that “[i]t could be argued that providing a monetary incentive to successfully fulfill the requirements of a wellness program renders the program involuntary” and that “where an employer decreases its share of the premium and increases the employee’s share, resulting in a significantly higher health insurance premium for employees who do not participate or are unable to meet the criteria of the wellness program, the program may arguably not be voluntary.”⁴⁷

In addition, on March 6, 2009, the Commission rescinded part of a January 6, 2009, informal discussion letter which provided, in part, that:

[A] wellness program would be considered voluntary and any disability-related inquiries or medical examinations conducted in connection with it would not violate the ADA, as long as the inducement to participate in the program did not exceed twenty percent of the cost of employee only or employee and dependent coverage under the plan, consistent with regulations promulgated pursuant to the Health Insurance Portability and Accountability Act.⁴⁸

Although rescinded, the above language indicates that the Commission has at least contemplated allowing a certain level of incentives to be offered in connection with disability-related inquiries or medical examinations conducted in connection with a wellness program. It further indicates that the Commission has, on at least this one occasion, looked to HIPAA guidance to shape the contours of the ADA.

At least partly as a result of Commission’s silence, the Eleventh Circuit recently weighed in on the treatment of wellness programs for purposes of the ADA. The particular concern has to do with a common design that conditions receipt of an incentive upon mere participation rather than outcomes-based wellness programs. In

⁴⁶ See EQUAL EMPLOYMENT OPPORTUNITY COMM’N, ENFORCEMENT GUIDANCE: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS OF EMPLOYEES UNDER THE AMERICANS WITH DISABILITIES ACT (ADA), Q&A 22 (2000), <http://www.eeoc.gov/policy/docs/guidance-inquiries.html>.

⁴⁷ See Commission Informal Discussion Letter (Jan. 23, 1998) (on file with Council).

⁴⁸ See Commission Informal Discussion Letter (Mar. 6, 2009), http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.

Seff v. Broward County,⁴⁹ the Eleventh Circuit upheld the district court's decision as to whether a participatory wellness program satisfied the ADA where it imposed a \$20 charge on each biweekly paycheck issued to employees who enrolled in the group health insurance plan but refused to participate in the County's wellness program, which required in part that employees complete online HRAs and take blood tests to measure their glucose and cholesterol levels. Employees diagnosed with asthma, hypertension, diabetes, congestive heart failure or kidney disease were given the opportunity to receive disease management coaching and certain free medications related to those conditions. Instead of looking at whether the wellness program is "voluntary" within the meaning of Title I of the ADA, the court relied on other provisions in the ADA (a provision creating a safe harbor for "bona fide benefit plans") to find that the wellness program complied with the ADA. We note that, despite the decision in *Seff*, the Commission's regional offices continue to undertake enforcement actions based on the "voluntary" standard and employers do not have the guidance from the Commission necessary to comply with the ADA.

KEY CONCERNS FOR EMPLOYERS AND RECOMMENDATIONS

As the statistics cited at the start of this testimony demonstrate, an increasing number of employers are offering wellness programs. Their sponsorship of these programs is motivated not only by a desire to control rising health care costs, but also by a desire to help promote worker health, increase worker morale, engagement and productivity, and to reduce absenteeism and presenteeism.

Notwithstanding employers' interest in wellness programs, a great deal of legal uncertainty exists with respect to the application of both GINA and the ADA to these programs. As noted above, existing guidance from the Commission is not clear regarding what constitutes a voluntary wellness program for purposes of the ADA. Moreover, questions remain regarding how GINA applies to various aspects of some common wellness program designs, including the use of wellness incentives in connection with spousal and dependent HRAs.

This legal uncertainty has only been exacerbated by certain enforcement actions that we understand have been initiated by various regional offices of the Commission with respect to employers' HIPAA-compliant wellness programs. These enforcement actions are troubling for employers because they fear that they will find themselves subject to similar litigation or enforcement actions notwithstanding their good faith efforts to comply with all clearly defined applicable laws and their programs' compliance with HIPAA.

The continued legal uncertainty with respect to GINA and the ADA has left many

⁴⁹ *Seff v. Broward County*, 691 F.3d 1221 (11th Cir. 2012).

employers confused as to how to proceed, and, left unaddressed, will have a chilling effect on the ability of employers to design and implement the wellness plans, even though these would be fully compliant with the comprehensive rules issued to implement the wellness provision of the ACA. Although the decision in *Seff v. Broward County* offers some comfort under the “bona fide benefit plan” exception, concerns remain in part because *Seff* is only binding in the Eleventh Circuit. In addition, the Commission’s regional offices continue to undertake enforcement actions based on the “voluntary” standard rather than the “bona fide benefit plan” exception, and employers do not have the guidance necessary to comply with the “voluntary” standard.

The unfortunate result of continued legal uncertainty would be that many American workers who could benefit from access to meaningful wellness programs (including those programs providing for disease management programs, smoking cessation programs, and/or expanded health education) would be left without.

Recommendation: Building on HIPAA’s Framework

We encourage the Commission to work within the existing HIPAA and ACA legislative and regulatory framework. As discussed above, HIPAA imposes a robust set of nondiscrimination rules on issuers and employers with respect to a very broad class of persons – effectively any group health plan participant that has a health status or condition, even where such status or condition falls short of constituting a disability for purposes of the ADA. In other words, HIPAA already casts a broad protective net – one that not only protects individuals with disabilities, but also the American worker or health plan participant more generally.

The Council fully respects the Commission’s existing and long-standing authority to implement and enforce the ADA, as well as other federal statutes. As the Commission now considers possible further wellness program standards, we urge you to recognize the comprehensive regulatory framework that already exists, including its protections for individuals with disabilities and beyond. This was recognized by Congress when it enacted the ACA, and we respectfully request that the Commission give effect to both the broad and protective reach of HIPAA as well as Congress’s express endorsement for HIPAA-compliant wellness programs as part of its enactment of the ACA.

We believe that the HIPAA regulatory framework is both comprehensive and workable, and if the Commission concludes that improvements are needed, all interested parties should come together in a meaningful and measured fashion to carefully consider the effects of changes to this existing framework. We are confident that the rights of all individuals can be adequately protected while preserving the ability of, and interests of employers in, sponsoring comprehensive wellness programs to the benefit of their employees and American society as a whole.

Thank you for your time. I would be happy to answer any questions you may have.