



TESTIMONY OF

CATHERINE BAASE, M.D.

ON BEHALF OF THE

THE DOW CHEMICAL COMPANY

AND

AMERICAN BENEFITS COUNCIL

**U.S. SENATE COMMITTEE
ON HEALTH, EDUCATION, LABOR AND PENSIONS
EMPLOYER WELLNESS PROGRAMS:
BETTER HEALTH OUTCOMES AND LOWER COSTS**

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My name is Catherine Baase. I am the Chief Medical Officer for The Dow Chemical Company (“Dow” or “the Company”). I am testifying today on behalf of my company and for the American Benefits Council (the “Council”). My colleague, Janet Boyd, currently serves as Chair of the Council’s Board of Directors.

Dow, founded in Michigan in 1897, has become one of the world’s leading manufacturers of chemicals and plastics. We supply products to customers in 160 countries around the world, connecting chemistry and innovation with the principles of sustainability to help provide everything from fresh water, food, and pharmaceuticals to paints, packaging and personal care products.

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. Many of the Council’s members are at the forefront of the workplace wellness revolution, developing programs to help employees live healthier lives and manage chronic conditions.

Dow and the Council are strong supporters of employer-based wellness programs as an important tool for achieving better health outcomes for not only our employees but also our communities as a whole. According to the Kaiser Family Foundation’s Employer Health Benefits 2014 Annual Survey, 98 percent of large companies (with 200 or more workers) and 73 percent of smaller companies in the United States offered at least one wellness program in 2014, and more than 75 percent of U.S. employees now have access to such programs.^{1 2} My testimony reviews both the recent studies supporting the need for employer engagement but also describes various types of employer-based programs and the need for strong public policy to support these programs.

CLEAR RATIONALE FOR EMPLOYER ENGAGEMENT

Key Points:

- Business/ Employers are absolutely essential to society/ countries achieving health for their people.

¹ Kaiser Family Foundation, [Employer Health Benefits 2014 Annual Survey – Wellness Programs and Health Risk Assessments](#) 196 (2014) [hereinafter KFF Survey].

² Sloan Center on Aging & Work at Boston College, [Fact Sheet 38: Health and Wellness Programs in the Workplace](#) 1 (July 2014)

- Success in engaging the business community, with appropriate actions as part of a broad societal strategy to improve health, is an imperative.
- To have optimal impact, employers need to have a comprehensive health strategy.
- The insight and business case for employer involvement in health has evolved. The health of employees and the communities in which the business operates have connection to multiple business/ employer priorities.
- It is possible to have a significant impact on the health of the employees through corporate health strategies and programs. The experience of Dow shares some of the impact of employer health strategies.

In November 2014, McKinsey Global Institute released a compelling document illustrating the overwhelming nature of the challenge our country faces with obesity and the importance of all sectors – including the business community – being involved if we hope to find a better future.³ The McKinsey Global Institute (MGI) is the business and economics research arm of McKinsey & Company, which was established in 1990 to develop a deeper understanding of the evolving global economy. Its goal is to provide leaders in the commercial, public and social sectors with the facts and insights on which to base management and policy decisions. Its discussion paper provides a perspective on the nature and causes of the obesity problem and it provides recommendations. The report states,

“Obesity is now a critical global issue, requiring a comprehensive intervention strategy rolled out at scale. More than 2.1 billion people – nearly 30 percent of the global population – are overweight or obese. That’s nearly two and a half times the number who are undernourished. Obesity, which should be preventable, is now responsible for about 5 percent of all deaths worldwide. If its prevalence continues on its current trajectory, almost half of the world’s adult population will be overweight or obese by 2030. This preliminary paper aims to start a global discussion on the components of a successful societal response.”

In its executive summary, MGI makes several main points summarized as follows:

- Any single intervention is likely to have only a small overall impact on its own. A systemic, sustained portfolio of initiative, delivered at scaled is needed.
- Education and personal responsibility are critical but not sufficient. Changes to the environment and societal norms are also needed.

³McKinsey Global Institute, [Overcoming obesity: An initial economic analysis](#) (November 2014).

- No individual sectors in society – governments, retailers, consumer-goods companies, restaurants, employers, media organizations, educators, health-care providers or individuals – on their own can address obesity. Success requires engagement from as many sectors as possible – together.
- Implementing obesity abatement will not be easy; (1) deploy as many interventions as possible at scale, (2) understand how to align incentives and build cooperation and (3) do not focus unduly on prioritizing.
- The evidence based on clinical and behavior interventions is far from complete, proving a barrier to action; this need not be so. Experiment, rather than waiting for perfect proof.

As noted in the third bullet above, no individual sector in society, whether government, retailers, consumer-goods companies, restaurants, employers, media organizations, educators, health-care providers or individuals on their own can address obesity. It requires engagement from as many sectors as possible.

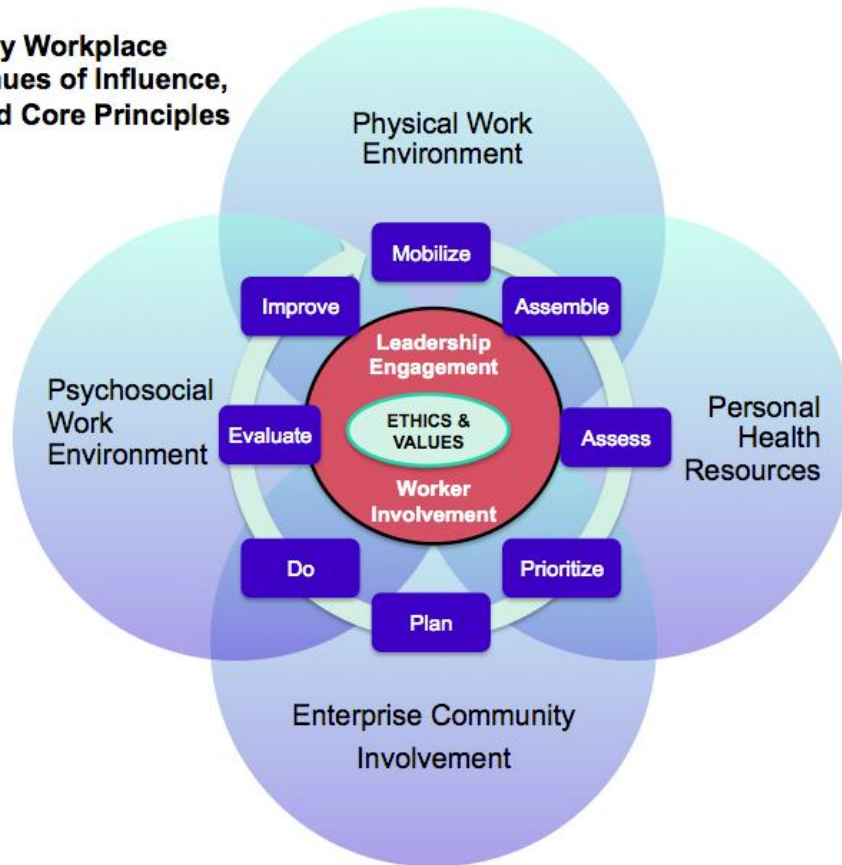
This McKinsey paper is focused on obesity. However, very similar reviews and positions have been taken by policy organizations and learned bodies about the ability to create healthy populations in general.

The World Economic Forum, in consideration of all non-communicable diseases, has stated that it is clear that chronic diseases are affecting social and economic capital globally. Non-communicable diseases are strongly connected to other global risks and fiscal crisis as well as underinvestment in infrastructure and food, water and energy security. The nature and extent of the challenges with non-communicable diseases will require the mobilization of social forces and people outside of health systems to make progress.⁴

The model of health created by the World Health Organization (WHO), and illustrated in their model, brings forward the concept that the approach to a healthy workplace includes an interface with the community, as noted in the Figure below.

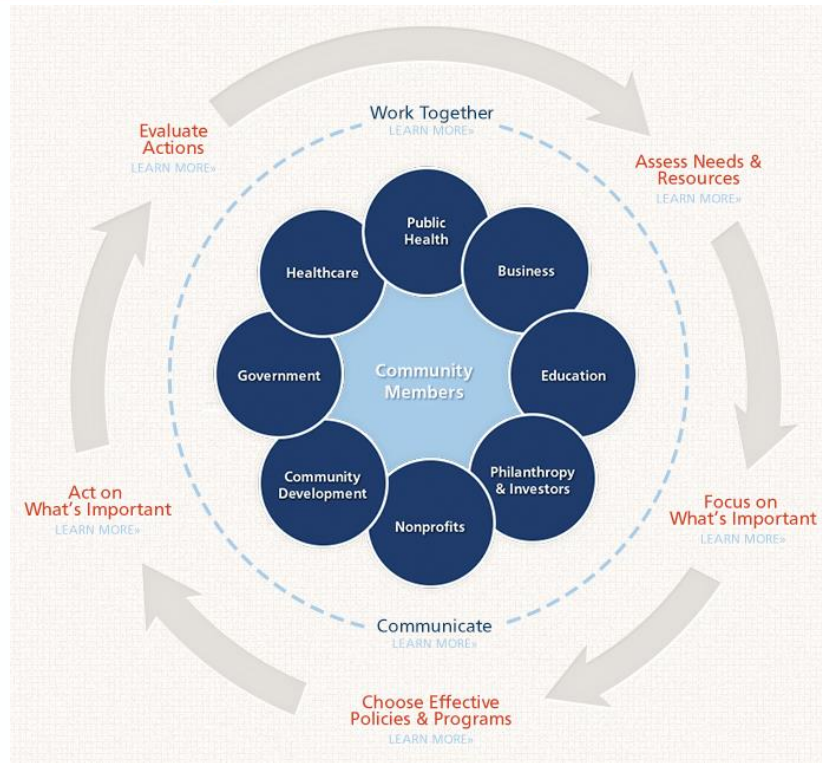
⁴ World Economic Forum, [Global Risks 2010](#) (2010)

Figure ES1
WHO Healthy Workplace
Model: Avenues of Influence,
Process, and Core Principles



The Roadmaps to Health program from the Robert Wood Johnson Foundation also notes the business community as a core element of the method to achieve healthier communities through collective impact as noted here and taken from its website.⁵

⁵ <http://www.countyhealthrankings.org/resources/101-presentation>



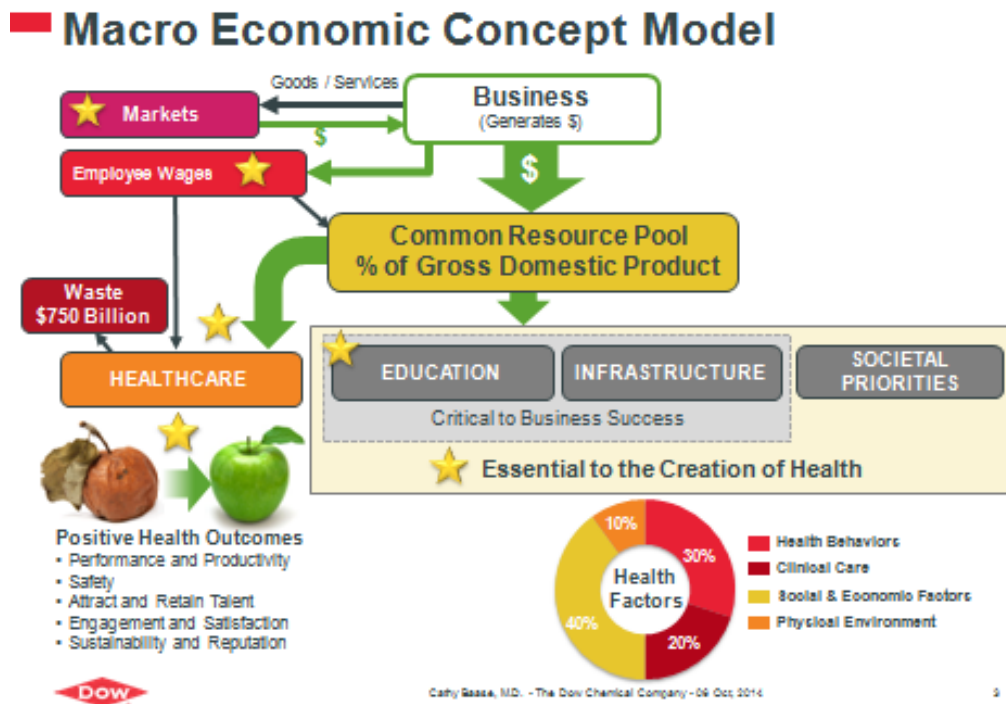
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The Institute of Medicine, as a part of the National Academy of Sciences, has convened a Population Health Roundtable (the “Roundtable”), of which I am privileged to be a member. The Roundtable has considered for over a year the nature of the situation this country faces in addressing the health of populations, the multiple causes and factors which are at work in creating health or lack of health and the path forward to a better future. They, too, have determined that it will take the engagement of multiple sectors of society to make progress, and that includes the business community/ employers. In July 2014, this Roundtable convened a workshop entitled “Business Engagement in Population Health Improvement,” which further explored the rationale, opportunity and case examples of the business/ employer community and their beneficial impact not only on their own employees but also the families of those employees and the communities where they operate.⁶

During this July workshop, I presented a view of the rationale for business engagement in health broadly by illustrating the nature of the current situation and the

⁶Institute of Medicine, [Business Engagement in Building Healthy Communities: Workshop Summary](#) (July 2014).

multiple pathways through which the current policy environment is adverse to business success, using the macro-economic model below, which highlights the alignment of business priorities and health.



One of challenges in population health is that no single entity feels ownership of, or has responsibility or accountability for taking control and finding solutions. The task now is to create collective ownership of population health and engage people from all sectors, including the business community.

The Macroeconomic Concept Model (the “Model”) focuses on how business generates money in society. Some of that money is used to pay employee wages and some percentage, in the form of taxes, goes into a common resource pool. A portion of the employee wages also contributes to the shared resource pool of taxes serving the needs of society. The Model illustrates six key ways in which the current health scenario is negatively impacting the success of the business sector. A better understanding of how the Model’s elements are destructive to a business’s success should motivate the business community to become more engaged. The six elements are:

- **Wage compression:** Increasing health care costs are resulting in wage compression; that is, a greater percentage of total compensation is going toward health care benefits versus take-home wages. This can be an issue in the ability to attract and retain global talent as well as achieve satisfaction and better morale in the workplace.

- **Reduced profits:** A greater percentage of total funds generated by business have to be allocated toward health care, resulting in reduced profits. Further, the significant waste in the healthcare system means that dollars invested to achieve health are not delivering high value.
- **Eroded foundation for business:** Money from the common resource pool funds health care as well as education, infrastructure, and other social priorities. Education and infrastructure are essential foundation elements for the success of business; however, they are being undermined by the diversion of greater and greater percentages of the societal resource base toward health care.
- **Less healthy workforce:** Business also needs healthy people in order to be successful. The unfortunate reality is that the increasing expenditures on healthcare are not delivering greater health for our population. Relative to other developed countries our people are losing ground on health markers. As businesses invest significantly in their employee base, they hope to have the full potential of those workers to achieve their goals. Diminished health impacts performance potential.
- **Impact on elements essential to the creation of health:** The same elements that are essential to business such as education are important social determinants of health. Diversion of spending away from education and infrastructure also undermines the creation of health.
- **Diminished purchasing power:** The cumulative impact of the current scenario is a diminished market because there is less take-home pay, and less disposable income.

EXPERIENCES OF THE DOW CHEMICAL COMPANY

What employers really want is better health for their people and the communities in which they operate, better quality of care overall and better value for their dollars spent in pursuit of health.

At Dow, we have over 100 years' experience with a corporate focus on the health of our people. We have had a formal health promotion initiative for nearly 30 years. Our efforts have been recognized as innovative and successful by numerous organizations all over the world. Over ten years ago, we established the Dow Health Strategy as a formal corporate level strategy. This strategy was built upon a comprehensive business case and is graphically illustrated below. Our actions within the strategy are focused in four key areas: prevention, quality and effectiveness of care, health system improvement and advocacy.

■ The Dow Health Strategy

Vision: We optimize health, human performance, and the long-term value for Dow



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Subsequent to developing the initial health strategy design, we have had continued insight and evolution of the business case and our action plan. Since our formal health promotion programs started, we have had comprehensive programs covering a broad array of prevention topics and utilizing a portfolio of methods from education to health assessments and counseling to group classes and targeted campaigns. We set policies like a tobacco policy. Over time, the health efforts became woven throughout the fabric of the organization. They became linked with safety efforts including off the job safety; they became a component of leadership development and employee training programs. We became intentional about setting a positive culture and environment for health including development of a corporate food philosophy and joint efforts with our facilities function to explore sit/ stand desks and other aspects of our building design and management which can impact health.

At this point, our business rationale links our health focus to many corporate priorities including safety, attracting and retaining talent, employee engagement and job satisfaction, corporate social responsibility, sustainability and profitability. This alignment of organizational priorities and the benefits of a healthy population reinforce the importance of healthy people to an organization. Thus, the value to the organization is broad and includes a serious focus on healthcare costs but much more.

■ Organizational Priorities: Broadened Alignment for Health

- Health Care Costs
- Safety
- Reliability
- Human Capital Priorities
 - Engagement
 - Talent: Attract and Retain
 - Human Performance
- Sustainability
- Corporate Social Responsibility
- Corporate Reputation

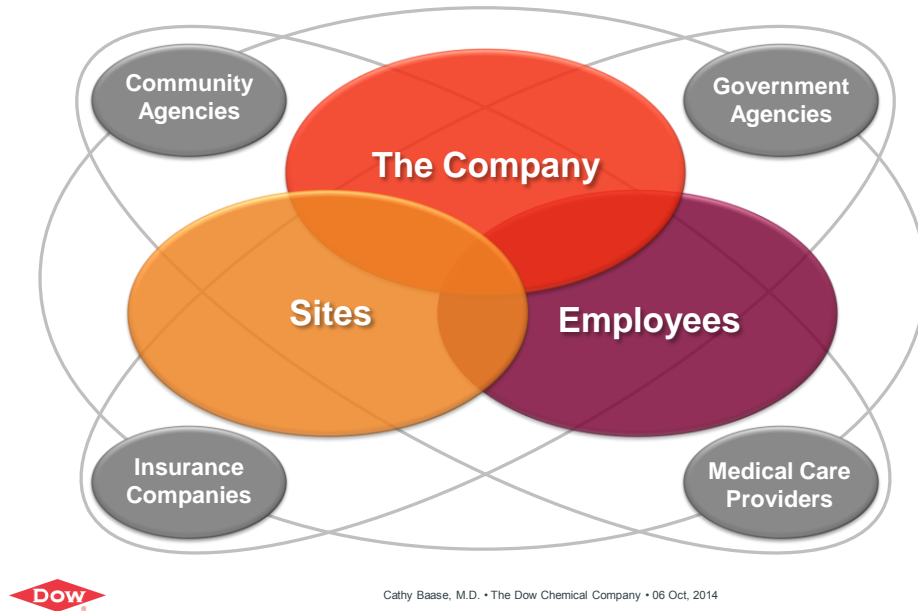


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We also recognize that in our pursuit of the goals of our health strategy, the communities within which we operate and the health situation of those communities can be a great asset and a multiplier to our efforts. We see the benefit of constructive collaboration with our communities.

We see our strategy as one of shared responsibility, as illustrated in the following diagram:

■ Shared Responsibility



As we pursued a “Culture of Health” several years ago, we launched an effort called the Healthy Workplace Index. This tool assigns scores for key elements and a cumulative score – Bronze, Silver, Gold or Platinum – for each Dow site in the U.S. and throughout the world. The use of this index is completely voluntary for each site, yet it has been widely used by the majority of sites across the Company. The elements of the index are illustrated by the following diagram:

■ Healthy Workplace Index – Key Elements

- Tobacco Policy enforcement
- Access to physical activity
- Access to healthy foods
- Case management
- Periodic health assessment participation
- Company directed exam participation
- Stress management
- Supportive work environment (composite index)

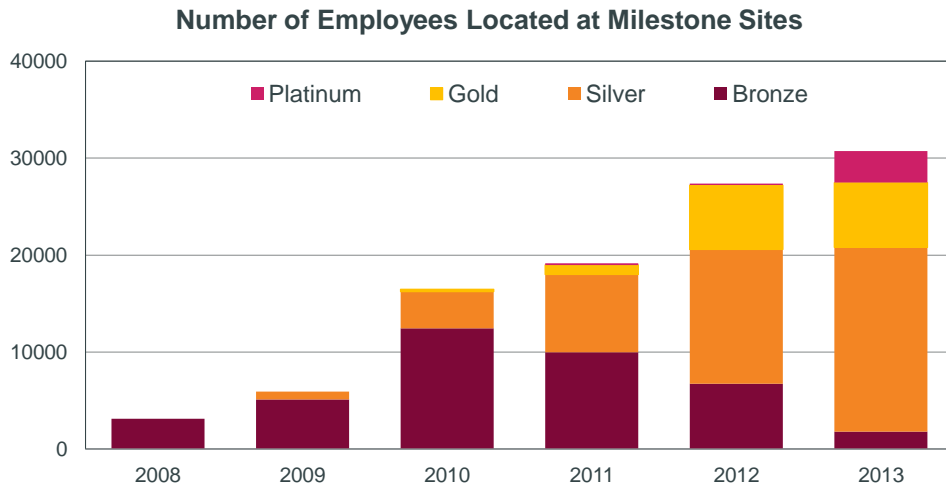


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The following chart shows the progress in achievement over time of scores and the increasing number of sites achieving higher milestones.

■ Healthy Culture: Healthy Workplace Index Progress



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We recognized the power of culture and environment in supporting healthy lives. As we worked to create and strengthen this culture in our workplaces, we began to bring into our view the opportunity to collaborate with others to create a community of health excellence where we operate. One example of this collaborative effort with the community is the Michigan Health Improvement Alliance serving 14 counties in central Michigan around our corporate headquarters. Since 2007, we have worked in a collective impact approach with all sector stakeholders in these counties. Through MiHIA, our communities are currently pressing to reduce waste and improve care through the “Choosing Wisely” campaign of the American Board of Internal Medicine Foundation. We are working to change the health system in our region to move upstream in the disease process by establishing a new norm and processes to identify and intervene to address pre-diabetes using the CDC’s evidence based intervention known as the Diabetes Prevention Program. More detailed information on the progress of this multi-stakeholder effort is available on the website.⁷

⁷<http://www.mihia.org>.

■ Community: Beyond the Company Walls

Michigan Health Information Alliance, Inc.

Regional not-for-profit multi-stakeholder coalition (www.mihia.org)

- Working to achieve the Triple Aim
- Community Dashboard



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DOW'S SYSTEM FOR MEASURING IMPACT AND APPROACH TO USE OF INCENTIVES

Throughout our corporate health efforts, we have implemented extensive measures to track outcomes. We track progress across our sites around the world. Participation in our health promotion programs is voluntary. We do not use financial incentives to drive participation or outcomes in our global worksite health programs. Our employees value the services we offer and the programs available to them. Our global participation rates are very high – approaching 90 percent for completion of health assessments.

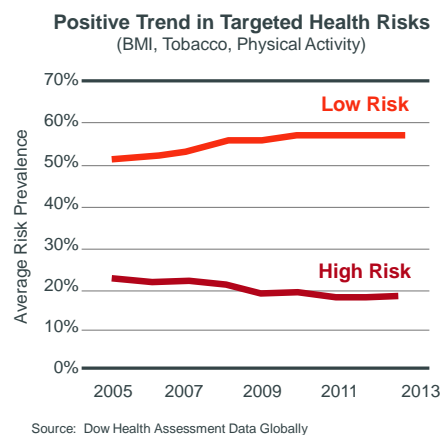
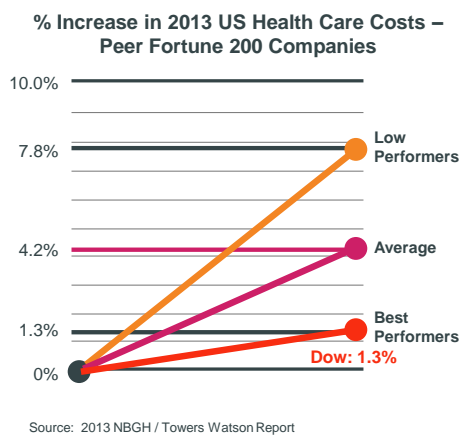
However, in our U.S. healthcare benefit plan, we do have one financial incentive. On January 1, 2010, we introduced a smoking surcharge for our medical plans (\$50 per month) and dental plans (\$10 per month). Of course one of the goals was to discourage smoking but the other purpose was just to recognize the increased cost of medical and dental coverage for a tobacco user. The surcharge can be avoided by agreeing to attend a tobacco cessation class. In the case of reporting smoking status and the report of attendance at a tobacco cessation class, both are self-attestation.

The impact of our efforts is evidenced in the graphic below. Specifically, the graph shows our experience in U.S. health care spending and our experience worldwide in tracking our top three priority health risks since 2004. Due to our 1.3 percent trend in 2013, Dow spent \$4.8 million less in 2013 U.S. health care costs than we would have spent had we experienced the industry average trend of 4.2 percent. Our five-year trend

is less than 2 percent. Recognizing favorable trend compounding over the last five years, we spent \$44.8 million less in 2013 than we would have spent in 2013 had we experienced average trend over the last five years.

Regarding health risks, since 2004 we have seen a more than a 15 percent increase in the percent of our employee population at low risk for BMI, physical activity and tobacco and a 28 percent decrease in the employee population at high risk for these same three risk factors. Further, a 2012 study conducted by Towers Watson comparing our population to peer companies with adjustments for demographics and other variables found that our entire covered lives in the U.S. healthcare plans population had a 9 percent better health risk profile than their book of business and our prevalence of chronic conditions was 17 percent less than others while we spent 17 percent less on chronic conditions.

■ Progress in Outcomes



OVERVIEW OF THE CURRENT STATE OF EMPLOYER SPONSORSHIP OF WELLNESS PROGRAMS

Experiences of other employers with wellness programs also evidence positive results. A global survey by Buck Consultants, representing the views of 1,041 employer respondents based in 37 countries, states the leading results of wellness programs are “reducing sick leave” and “presenteeism” (the practice of attending work while sick), and “improving workforce morale and engagement”.⁸

⁸ Buck Consultants, [Working Well: A Global Survey of Health Promotion and Workplace Wellness and](#)

Data from the 2013 RAND Employer Survey, sponsored by the U.S. Department of Labor, suggest that employers view the impact of their wellness programs overwhelmingly as positive, with 78 percent stating that it decreased absenteeism and 80 percent stating that it increased productivity.⁹

A 2013 Society of Human Resource Management (SHRM) Survey reported that three quarters (76 percent) of employers said their wellness initiatives are “somewhat” or “very effective,”¹⁰ while 32 percent of respondents to a 2014 Mercer Survey said specifically that the health risks of the population served by their wellness programs were improving.¹¹ These results support published research findings that workplace wellness programs can improve health status, as measured with physiological markers (such as body mass index, cholesterol levels and blood pressure).¹²

Like Dow’s experience, other employers’ programs hold the promise of more direct economic benefits under the principle that successful preventive actions, better-managed chronic conditions and fewer episodes of care will result in reduced health service utilization and fewer claims. The Buck Consultants study found that per-employee per-year health care costs were identified as a valuable outcome by 68 percent of employees.¹³

Indeed, the RAND study found that while it is not clear at this point whether improved health-related behavior will translate into lower health care cost, there is reason to be optimistic. Fully 60 percent of respondents indicated that their wellness program reduced health care cost,¹⁴ with reductions in inpatient costs accounting for 68 percent of the total cost reduction, compared to outpatient costs (28 percent) and prescription drug costs (10 percent).¹⁵

Employers’ Program Designs Vary

Employers have developed a variety of wellness program designs. The most common offerings generally include:

[Productivity Strategies, Executive Summary](#) 2 (2014)

⁹ RAND, [Workplace Wellness Programs Study: Final Report](#) 53 (2013)

¹⁰ Society of Human Resource Management, [State of employee benefits in the workplace – Wellness initiatives](#) 4 (2013)

¹¹ Mercer, [Taking health management to a new level](#) (2014) via Sloan Center, *supra* note 2, at 3

¹² RAND, *supra* note 4 at 61

¹³ Buck Consultants, *supra* note 3, at 4

¹⁴ RAND, *supra* note 4 at 53

¹⁵ RAND, *supra* note 4 at 57

- immunizations/flu shots (53 percent of all firms, 87 percent of large firms)
- web-based resources for healthy living (39 percent/77 percent)
- wellness newsletters (34 percent/60 percent)
- employee assistance programs (“EAPs”) (29 percent/79 percent)
- gym membership discounts or on-site exercise facilities (28 percent/64 percent)
- smoking cessation programs (27 percent/64 percent)
- biometric screening programs (for blood pressure, cholesterol, glucose, and body fat) (27 percent/51 percent)
- lifestyle or behavioral coaching (23 percent/58 percent)
- nutrition/healthy living classes (20 percent/47 percent)
- weight-loss programs (19 percent/48 percent)¹⁶

Many of these design elements are also common to value-based insurance designs (V-BID), which are related to wellness programs in that they also make use of financial incentives to increase health outcomes, similar to how Dow implemented our smoking incentive relating to our premium levels. For example, in one study, completion of a health risk assessment was a V-BID participation requirement for 26 percent of companies; participation in a disease management, weight management or tobacco cessation program was a requirement for 29 percent of companies.¹⁷

Additionally, many employers expand these programs to the family members of their employees. The Buck Consultants survey found that 62 percent of programs include spouses, 52 percent include domestic partners and 43 percent include children.¹⁸ A separate study found that 17 percent of firms offer wellness programs to their retirees.¹⁹

The evidence base regarding workplace health promotion has evolved and continues to advance. Employers and vendors are making greater use of population strategies and evidence based approaches. There is more advanced thinking to create cultures which advance health. Organizations are increasing their sophistication in establishing comprehensive efforts and an overarching health strategy. Consistent with the Center for Disease Control and Prevention’s “Health in All Policies” efforts, the worksite is a critical venue to address health needs and health improvement. Advanced approaches to population health in communities with an emphasis on Patient Centered Medical Homes, are working to make sure that the “medical neighborhood” is functioning in a strong manner knowing that everything cannot be accomplished in a

¹⁶ KFF Survey, *supra* note 1, at 199. Similar results also available from Optum, [Fifth Annual Wellness in the Workplace Study: An Optum Research Update](#) 5 (2014)

¹⁷ Aon Hewitt, [2014 Health Care Survey](#) 33 (2014)

¹⁸ Buck Consultants Survey Executive Summary, *supra* note 3, at 3.

¹⁹ Optum, *supra* note 12 at 7

physician's office. All of this underscores the importance of supporting and keeping employers engaged in addressing health. It matters to society and to the quality of life of those in the workforce.

CHALLENGES WITH CURRENT PUBLIC POLICY

Employers applaud Congress for working on a bipartisan basis to craft the wellness provisions in the Patient Protection and Affordable Care Act (PPACA) that built on the existing framework created in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PPACA's bipartisan provision increased employer flexibility in designing programs to improve the health of employees and their families. Additionally, the PPACA has helped to cement wellness programs as one of the cornerstones of health reform.

A critical component of encouraging employers to offer meaningful wellness programs is consistent federal policy that promotes the health of Americans and is aligned across multiple agencies and Congress. We welcome the opportunity to work with this committee, the Equal Employment Opportunity Commission (EEOC) and other stakeholders to provide legal and regulatory certainty to employers offering wellness programs to their employees.

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 EEOC 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. 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”).²⁰ 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.²¹ An exception to the general rule allows premium discounts, rebates, and cost-sharing modifications (all forms of incentives or rewards) in return for adherence to certain programs of health promotion and disease prevention, such as a wellness program.²²

Final regulations issued by the DOL, HHS and Treasury to implement these provisions of HIPAA took effect in 2007, and impose rules that certain wellness programs must satisfy in order to allow incentives to be provided to participants.²³ 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.²⁴ 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.²⁵

The requirements are 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 (1) “not be a subterfuge for discriminating based on a health factor, and not be highly suspect in method,” and (2) 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.

²⁰ See Code § 9802, ERISA § 702, PHSA § 2705.

²¹ 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).

²² Code § 9802(a)(1).

²³ Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014 (Dec. 13, 2006).

²⁴ 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.

²⁵ See 26 C.F.R. § 54.9802-1(f)(2). Examples include not smoking, attainment of certain biometric screening results, and achieving exercise targets.

Patient Protection and Affordable Care Act

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 PPACA. Specifically, PPACA Section 1201 codifies the HIPAA regulations and increases the permitted incentive from 20 percent to 30 percent (and permits regulators to increase incentives up to 50 percent in their discretion). This is a rare bipartisan provision in the controversial health care reform law and reflects Congress's approval of the offering of incentives for health-contingent wellness programs.

On June 3, 2013, the DOL, HHS and Treasury issued final rules on "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans."²⁶ These new final HIPAA wellness rules are based on the same general framework as the existing HIPAA wellness rules and incorporate changes that were mandated by the PPACA, including increased limits on the amount of health-based wellness program rewards that a plan can offer or penalties it can impose.

Under the PPACA – as under the previous HIPAA rules – plans first must determine whether their wellness program is Participatory or Health-Contingent. A program will be considered Participatory if none of the conditions to obtain a reward are based on an individual satisfying a health standard, and thus participatory programs are not required to meet the HIPAA wellness rule requirements. Health-Contingent programs must meet the additional requirements of the HIPAA wellness rules in order to be in compliance with the HIPAA nondiscrimination rules. A wellness program is considered to be Health-Contingent if it requires an individual to satisfy a standard related to a health factor in order to obtain a reward. The June 2, 2013, final rules break the Health-Contingent category down further into Activity-Based and Outcome-Based, with different requirements for each depending on the type of program.

The PPACA 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 PPACA Section 1201 discussed above, there are numerous other provisions relating to wellness initiatives in the PPACA, including:

- Employer wellness program evaluation tools.²⁷
- Health plan quality-of-care report and employee notice.²⁸

²⁶ 78 Fed. Ref. 33158

²⁷ PPACA §§ 4303, 10404.

²⁸ PPACA § 1001.

- Small-employer wellness program grants.²⁹

These provisions are inextricably linked to the fundamental fabric of the PPACA 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 EEOC, 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, 2009.³⁰ 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:

- 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.³¹

The prohibition on requesting, requiring or purchasing genetic information at any

²⁹ PPACA § 10408.

³⁰ 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).

³¹ Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. at 51,665.

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.³² 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.³³ “Genetic information” is defined for purposes of GINA Title I to include family medical history.³⁴

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).³⁵ 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 EEOC’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 were published in the Federal Register on November 9, 2010.³⁶

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.³⁷ 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

³² Code § 9832(d)(10)(B).

³³ 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).

³⁴ 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).

³⁵ Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. at 51,669.

³⁶ Regulations Under the Genetic Information Nondiscrimination Act of 2008, 75 Fed. Reg. 68,912 (Nov. 9, 2010).

³⁷ See 29 C.F.R. § 1635.4.

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 (1) is written in language reasonably likely to be understood by the individual from whom the information is sought, (2) describes the information being requested and the general purposes for which it will be used, and (3) 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).³⁸

Incentives may not be offered for individuals to provide genetic information.³⁹ 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 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.⁴⁰

³⁸ 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.

³⁹ *See* 29 C.F.R. § 1635.8(b)(2)(ii).

⁴⁰ 29 C.F.R. §1635.8(b)(2)(iii).

Americans with Disabilities Act

The EEOC 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.⁴¹ The ADA 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.⁴²

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 EEOC 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.⁴³ The EEOC has stated in certain of these informal discussion letters that it has not 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 EEOC 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.⁴⁴

The EEOC has, on at least two occasions, come close to providing clarifying guidance. In 1998, the EEOC 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

⁴¹ 42 U.S.C. § 12112(a).

⁴² 42 U.S.C. § 12112(d).

⁴³ 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>.

⁴⁴ 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>.

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.”⁴⁵

In addition, on March 6, 2009, the EEOC 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.⁴⁶

Although rescinded, the above language indicates that the EEOC 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 EEOC 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 the EEOC’s silence, the Eleventh Circuit 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 *Seff v. Broward County*,⁴⁷ 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 EEOC’s regional offices continue to undertake enforcement actions based on the “voluntary” standard and employers do not have the guidance from the EEOC necessary to comply with the ADA.

⁴⁵ See Commission Informal Discussion Letter (Jan. 23, 1998) (on file with Council).

⁴⁶ See Commission Informal Discussion Letter (Mar. 6, 2009), http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.

⁴⁷ *Seff v. Broward County*, 691 F.3d 1221 (11th Cir. 2012).

KEY CONCERNS FOR EMPLOYERS AND POLICY RECOMMENDATIONS

Notwithstanding employers' increasing interest in establishing 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 EEOC 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.

The Council testified before the EEOC⁴⁸ in a May 2013 hearing, describing employers' strong concern about the ongoing legal uncertainty that exists with respect to the application of the ADA and GINA to wellness programs. The Council also urged "federal agencies promulgating regulations should proceed in a consistent, collaborative manner that supports participatory and outcomes-based wellness initiatives" in our new strategic plan, *A 2020 Vision*⁴⁹.

This legal uncertainty has been exacerbated by certain enforcement actions initiated by regional offices of the EEOC with respect to employers' HIPAA and PPACA-compliant wellness programs. Recent enforcement actions brought by the EEOC allege certain wellness programs violate the ADA and GINA by imposing penalties on employees who decline participation in the company's biometric screening program. These legal actions have had a chilling effect on employer wellness programs.

Additionally, the EEOC announced in its most recent semi-annual regulatory agenda that it intends to issue regulations later this year addressing wellness programs under the ADA and GINA. However, the actual timetable for the issuance of such guidance is uncertain.

Unfortunately for employers operating in good faith, the EEOC decided to pursue litigation before issuing guidance on this matter. This is very frustrating for employers who care about the well-being of their employees and take seriously their compliance obligations. It is impossible for employers to abide by rules that do not exist.

The unfortunate result of continued legal uncertainty would be that many American workers who could benefit from access to meaningful wellness would be left without.

⁴⁸ http://www.americanbenefitscouncil.org/documents2013/wellness_eecouncil-simon-testimony050813.pdf

⁴⁹ <http://www.americanbenefitscouncil.org/newsroom/2020vision.cfm>

Recommendation: Building on HIPAA's Framework

It is my hope that this testimony has strongly reinforced the imperative to support and strengthen the efforts of employers to be effective in their role of advancing the health of people. The Council and Dow encourage Congress and/or the EEOC to work within the existing HIPAA and PPACA legislative and regulatory framework to provide certainty to employers. 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.

As mentioned, the EEOC announced in its most recent semi-annual regulatory agenda that it intends to issue regulations later this year addressing wellness programs under the ADA and GINA. We fully respect the EEOC's existing and longstanding authority to implement and enforce the ADA, as well as other federal statutes. As the Committee considers possible further wellness program standards or other legislative parameters applicable to the EEOC, we urge you to recognize the comprehensive regulatory framework that already exists, including protections for individuals with disabilities and beyond. The employer community appreciates this Committee's recognition of the importance of wellness programs and the existing regulatory framework that protects consumers, and notes PPACA was amended on a bipartisan basis to endorse and expand HIPAA-compliant wellness programs.

We believe that the HIPAA regulatory framework is both comprehensive and practical, and if the Committee or the EEOC 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.

If this Committee considers advancing legislation pertaining to wellness programs, it would be helpful to provide relief from certain provisions of the ADA and GINA to employers that are complying with HIPAA and PPACA.

For example, with respect to Health-Contingent wellness programs (including Activity-Based and Outcome-Based programs), legislation could deem such programs to comply with the ADA to the extent the program complies with existing HIPAA and PPACA regulations. With respect to participatory programs, such programs could be deemed to comply with the ADA, provided the program is reasonably designed to promote health or prevent disease and the program does not use a reward that exceeds 30 percent of the total premium cost (or up to 50 percent at the regulator's discretion). With respect to all three categories of programs (i.e., participatory, Activity-Based and Outcome-Based programs), legislation could also specify that such programs would not

be found to violate GINA solely because a program requests current medical information from a participant's spouse (or vice-versa) so long as the information is used solely with respect to the participant's spouse.

CONCLUSION

There is no single tactic for Dow's success or the successes of other employer programs. Rather, a collective solution is needed, focused on each company's health opportunity. For Dow, the solution includes an integrated Health Strategy, comprehensive health programs, two decades of sustained commitment and a major focus within our culture. As the Council's *A 2020 Vision* states, employer-sponsored benefit plans are now being designed with the express purpose of giving each worker the opportunity to achieve personal health and financial well-being. This well-being drives employee performance and productivity, which drives successful organizations. To maintain global competitiveness and help to achieve health in our communities, American companies must encourage healthy behavior with every tool in our toolkit. In other words, a healthy workforce is a productive workforce, and a productive workforce makes for a healthier American economy.

Thank you for your interest in employer sponsored wellness programs. I appreciate the opportunity to testify, and the Council and I look forward to working with you to restore certainty to employers focusing on improving the health of their workforces.