



**AMERICAN BENEFITS
COUNCIL**

TESTIMONY OF

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ON BEHALF OF THE

AMERICAN BENEFITS COUNCIL

BEFORE THE

**U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND THE WORKFORCE
SUBCOMMITTEE ON WORKFORCE PROTECTIONS**

**HEARING ON H.R. 548, "CERTAINTY IN ENFORCEMENT ACT OF
2015"; H.R. 549, "LITIGATION OVERSIGHT ACT OF 2015"; H.R. 550,
"EEOC TRANSPARENCY AND ACCOUNTABILITY ACT"; AND H.R.
1189, "PRESERVING EMPLOYEE WELLNESS PROGRAMS ACT"**

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My name is Tamara M. Simon, and I am the Managing Director of the Knowledge Resource Center and the Career Practice at Buck Consultants, a Xerox Company. 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. Many of the Council’s members are at the forefront of the workplace wellness revolution, developing programs to help employees live healthier lives.

As stated in the Council’s recent public policy strategic plan, [*A 2020 Vision: Flexibility and the Future of Employee Benefits*](#),¹ 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, in turn, drives successful organizations.

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.

We applaud Congress for having worked 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 wellness provisions increased employer flexibility in designing programs to improve the health of employees and their families. Additionally, it signaled a recognition that wellness programs are a cornerstone of health reform.

Notwithstanding employers’ increasing interest in establishing wellness programs, a great deal of legal uncertainty exists with respect to the application of both the Genetic Information Nondiscrimination Act (GINA) and the Americans with Disabilities Act (ADA) to these programs. To address this, the Council’s recent public policy strategic plan, [*A 2020 Vision: Flexibility and the Future of Employee Benefits*](#), notes that “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.” Unfortunately, existing guidance from the U.S. Equal Employment Opportunity Commission (EEOC) is not clear regarding what constitutes a

¹ <http://www.americanbenefitscouncil.org/newsroom/2020vision.cfm>

voluntary wellness program for purposes of the ADA and questions remain regarding how GINA applies to various aspects of some common wellness program designs.

My testimony will describe the current state of employer-sponsored wellness programs. Not only are these programs important for achieving better health outcomes for employees, they also have the potential to increase employee productivity, improve workforce morale and engagement and reduce health care spending. The bulk of my data is drawn from Buck Consultants' 2014 survey report [Working Well: A Global Survey of Health Promotion, Workplace Wellness and Productivity Strategies](#),² which represents the views of 1,041 employer respondents based in 37 countries, including 562 respondents in the United States alone.

I will also explain how ongoing legal and regulatory uncertainty is preventing more employers from sponsoring wellness programs, and how House Education and the Workforce Chairman John Kline's Preserving Employee Wellness Programs Act (H.R. 1189) can help alleviate the problem.

WHAT IS A WELLNESS PROGRAM?

HealthCare.gov defines a wellness program³ as "a program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings."

As we study wellness at Buck, with the benefit of a broad range of employer experience, we have learned to subdivide wellness strategies into three distinct phases.

Wellness 1.0 demonstrates a focus on general health promotion and prevention activities, such as fun runs, competitions, and health risk appraisals, and some interventions such as tobacco cessation. Within this phase, the employer makes little or no measurement of outcomes.

Wellness 2.0 incorporates rapid adoption of health risk appraisals and biometric screening to assess the health of the employee population. These more advanced approaches are increasingly integrated with employee assistance programs (EAPs)⁴

² Buck Consultants, Working Well: A Global Survey of Health Promotion and Workplace Wellness and Productivity Strategies (2014)

³ See <https://www.healthcare.gov/glossary/wellness-programs/>

⁴ According to the IFEBP, an EAP is an "employment-based program designed to assist in the

and/or disease management programs, often leveraging portals and tracking of incentives. External (often financial) incentives are more frequently used to motivate participation in various activities, sometimes with the goal of meeting defined clinical outcomes.

Wellness 3.0, the most advanced approach to wellness, encompasses a broader focus on *overall* well-being, including a more holistic view and integrated approach to supporting employees in their health, wealth and careers, with employers taking a shared responsibility for well-being as part of a compelling value proposition for employees. Sophisticated measurement and metrics guide a health and human resource strategy that is directly tied to the overall success of corporate objectives. While external incentives are often still used, Wellness 3.0 relies on the development of intrinsic incentives/motivators and the value a supportive company culture and workplace environment can play in behavior change, leveraging newer personal engagement methods such as social media, gamification, mobile technology, automated coaching, and personalized challenges. Very often, these programs are extended more fully to the family and sometimes to the community at large.

This holistic approach is consistent with the Council's *2020 Vision*, in which we posit that health and retirement benefits will no longer be considered in separate silos, instead focused on the concept of "personal health and financial well-being," encompassing physical and mental health as well as financial security, both when actively employed and in retirement.

To start on this path, employers have developed a variety of wellness program designs. The most recent Buck Consultants survey lists the following health promotion/wellness components, from most prevalent to least prevalent, in the United States:

1. Employee Assistance Program (EAP)
2. On-site immunizations/flu shots
3. HR policies (e.g., flexible work schedules, break policies, paid time off policies)
4. Regular communications (e.g., online mailings, posters)
5. Health risk appraisal (health and lifestyle questionnaire)
6. Nurse line or other health decision phone support
7. Biometric health screenings (such as blood pressure, cholesterol, glucose, body fat)
8. Ergonomic adaptations and awareness

identification and resolution of a broad range of employee personal concerns that may affect job performance. These programs deal with situations such as substance abuse, marital problems, stress and domestic violence, financial difficulties, health education and disease prevention. The assistance may be provided within the organization or by referral to outside resources. Also called an employee assistance plan." International Foundation of Employee Benefit Plans, *Benefits and Compensation Glossary*, 12th Edition, 185 (2010)

9. Work/life balance support (e.g., legal, financial services, elder or child care support)
10. Telephonic chronic disease management support or coaching

The fastest-growing wellness programs in the United States include:

1. Telephonic physician support (telemedicine services)
2. Cycle-to-work program
3. On-site healthy lifestyle programs and coaching (e.g., nutrition, weight loss, stress reduction, smoking cessation)
4. Personal health record (electronic summary of personal health information)
5. On-site medical facility

In particular, telehealth services are projected to grow at an annual rate of 56 percent through 2018, suggesting that program design and technological advancement go hand-in-hand.⁵

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. Data indicates that positive reinforcement or “carrots” are more likely to be used than penalties or “sticks” in connection with wellness programs.

90 percent of U.S. employers with wellness programs responding to the Buck survey currently offer incentives, including rewards, penalties, or both, to encourage participation in wellness initiatives. The most common activities for which incentive rewards or penalties are offered include the completion of a health risk appraisal or screening, or participation in workplace health “challenges” (such as walking or weight loss).

Incentives most frequently take the form of gift cards, travel, merchandise or cash awards, although some employers offer reduced premium cost-sharing or lower deductibles, or provide for additional employer contributions to an account-based arrangement (such as employer flex credit contributions to health flexible spending arrangements or employer contributions to Health Savings Accounts or health reimbursement arrangements.)

According to *The Wall Street Journal*, “Studies have shown that [wellness] program participation rates can be pushed from 40 percent without an incentive to more than 70 percent with a \$200 incentive and to 90 percent when incentives are built into health-

⁵ The Council’s *A 2020 Vision* includes a specific goal and recommendations related to the use of continually evolving technology, including (1) clear guidelines for privacy of individualized information, (2) adoption of a “presumption of good faith” standard for the use of technology and (3) adoption of a “least burdensome compliance” standard for benefit plan regulations related to technology.

plan premiums or deductibles.”⁶

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 responding 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).⁷

A company’s wellness strategy is dictated not only by its choice of programs but also by its participant scope. Our survey found that 62 percent of programs include spouses, 52 percent include domestic partners and 43 percent include children. A separate study found that 17 percent of responding firms offer wellness programs to their retirees.⁸

Additionally, as suggested in the Council’s recent testimony⁹ before the Senate Health, Education, Labor and Pensions Committee, delivered by Catherine Baase, Chief Medical Officer for The Dow Chemical Company, population health is best achieved with business strategies that address employees as well as the community. 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.

WHY WELLNESS?

The development and implementation of a wellness strategy requires substantial financial, intellectual and human capital on the part of employers. This investment is justified by the promise of improved employee well-being, increased productivity and lower long-term health costs.

While “improving worker productivity and reducing presenteeism (the practice of attending work while sick)” is cited as the most important wellness program objective on a global basis (with 82 percent of respondents calling it “very important” or “extremely important”), these 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.

⁶ Michael P. O’Donnell, [Should Employees Get Insurance Discounts for Completing Wellness Programs?](#), *Wall Street Journal*, Feb. 18, 2013, at R5.

⁷ Aon Hewitt, 2012 Health Care Survey 35 (2012).

⁸ Optum, [Fifth Annual Wellness in the Workplace Study: An Optum Research Update](#) 7 (2014)

⁹ See <http://www.help.senate.gov/imo/media/doc/Baase2.pdf>

The potential for cost savings is particularly appealing to U.S. employers, with 88 percent of respondents in the United States telling Buck that “reducing health care or insurance premium costs” is “very important” or “extremely important.” While measurement is still inconsistent even among program sponsors, 28 percent of employers told us that their wellness program had an impact on their population’s health care trend rate, and 68 percent of those respondents reported a trend rate reduction of two percent or more. The potential of wellness programs to reduce costs is particularly important for employer health plan sponsors as they assess the impact of the PPACA’s 40 percent excise tax on “high-cost” plans on their health benefits coverage.¹⁰ Although the tax is not effective until 2018, employers are already responding by considering and implementing changes to health benefits coverage to help avoid the excise tax.

A 2013 RAND Employer Survey¹¹ examining wellness program outcomes, sponsored by the U.S. Department of Labor, 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,¹² with reductions in inpatient costs accounting for 68 percent of the total cost reduction, compared to outpatient costs (28 percent) and prescription drug costs.¹³

The available evidence also supports the aspirational goals of wellness programs – like improving productivity, morale and safety. Data from the 2013 RAND survey shows 78 percent of responding employers stated that their wellness program has decreased absenteeism and 80 percent stated that it increased productivity.¹⁴ Likewise, 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.¹⁵

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).¹⁶ According to our data, 53 percent of responding employers were measuring specific outcomes from health promotion programs in 2014, as compared to only 35 percent in 2012.

¹⁰ Code section 4980I imposes a 40 percent excise tax on an “applicable employer-sponsored coverage” offered an employee that exceeds specified statutory thresholds (For 2018, the thresholds are \$10,200 for self-only coverage, and \$27,500 for coverage other than self-only, subject to certain adjustments).

¹¹ RAND, [Workplace Wellness Programs Study: Final Report](#) (2013)

¹² Id at 53

¹³ Id at 57

¹⁴ Id at 53

¹⁵ Mercer, [Taking health management to a new level](#) (2014) via Sloan Center, *supra* note 2, at 3

¹⁶ RAND, *supra* note 4 at 61

The evidence that workplace health promotion is effective continues to evolve, with employers and vendors making greater use of population strategies and evidence-based approaches. As they do, existing strategies will evolve correspondingly and adoption of new programs will begin.

THE CURRENT STATE OF EMPLOYER SPONSORSHIP OF WELLNESS PROGRAMS

The prospect of a healthier workforce has compelled a growing number of companies to develop and implement wellness strategies. A full 65 percent of respondents to Buck's 2014 survey indicated that they have a wellness strategy, up from 49 percent in 2007. This 65 percent includes the 29 percent who said their strategy was fully implemented and another 31 percent who said their strategy was partially implemented. These results are consistent with other recent broad-based surveys from Willis,¹⁷ SHRM¹⁸ and The Families and Work Institute.¹⁹

The trend is particularly strong among large employers. According to the Kaiser Family Foundation's Employer Health Benefits 2014 Annual Survey,²⁰ 98 percent of large U.S. companies (with 200 or more workers), compared to 73 percent of smaller U.S. companies, offered at least one wellness program in 2014. Large firms are also more likely to offer financial incentives to employees for participating (36 percent vs. 18 percent).²¹

It is estimated that more than 75 percent of U.S. employees now have access to wellness programs.²²

The remarkable take-up of these programs by employers and employees, combined with the capacity and incentives for growth, make wellness an area of tremendous promise for the future of health care and employer-sponsored benefits. The Council believes that public policy should generally support private sector investment in wellness by giving all employers the flexibility they need to administer these programs while encouraging smaller employers to develop their own strategies.

¹⁷ Willis, [The Willis Health and Productivity Survey Report](#) (2014)

¹⁸ SHRM, [State of Employee Benefits in the Workplace – Wellness Initiatives](#) (2013)

¹⁹ Matos, K., & Galinsky, E., Families and Work Institute, [2014 National Study of Employers](#) (2014)

²⁰ Kaiser Family Foundation, [Employer Health Benefits 2014 Annual Survey – Wellness Programs and Health Risk Assessments](#) 196 (2014)

²¹ Id at 197

²² Sloan Center on Aging & Work at Boston College, [Fact Sheet 38: Health and Wellness Programs in the Workplace](#) 1 (July 2014)

CHALLENGES WITH CURRENT PUBLIC POLICY

Employers applaud Congress for working on a bipartisan basis to craft the wellness provisions in the PPACA that built on the existing framework created in the 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 appreciate the work of this committee in introducing the Preserving Employee Wellness Programs Act, a bill that clarifies that wellness programs that comply with HIPAA and the PPACA will not violate the ADA or GINA. We look forward to continuing 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 through 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 provisions to the Internal Revenue Code ("Code"), the Employee Retirement Income Security Act ("ERISA"), and the Public Health Service Act ("PHSA")²³ that generally 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,

²³ See Code § 9802, ERISA § 702, PHSA § 2705.

disability.²⁴ An exception to the general rule allows plans and issuers to provide premium discounts, rebates, and cost-sharing modifications in return for an individual's adherence to certain programs of health promotion and disease prevention, such as a wellness program.²⁵

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.²⁶ 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.²⁷ 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.²⁸

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.

Patient Protection and Affordable Care Act

Congress signaled its strong support for wellness program incentives 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

²⁴ 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).

²⁵ Code § 9802(a)(1).

²⁶ Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014 (Dec. 13, 2006).

²⁷ 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.

²⁸ See 26 C.F.R. § 54.9802-1(f)(2). Examples include not smoking, attainment of certain biometric screening results, and achieving exercise targets.

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."²⁹ These final HIPAA wellness rules are based on the same general framework as the 2007 HIPAA wellness rules and incorporate the changes detailed in the PPACA.

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 3, 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.

These provisions demonstrate the clear intent of Congress and the Obama Administration that wellness programs should be 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 affected 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, 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. Interim final rules were published in

²⁹ 78 Fed. Ref. 33158

the Federal Register on October 7, 2009.³⁰ 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 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 a health risk assessment (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.

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

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.

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 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,

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.

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).

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

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

⁴⁰ 29 C.F.R. §1635.8(b)(2)(iii).

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

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 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

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>.

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.

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.

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.

I testified on behalf of the Council 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 the Council's *A 2020 Vision* strategic plan.

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.

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

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

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.

BUILDING ON THE HIPAA AND PPACA FRAMEWORK BY PASSING THE PRESERVING EMPLOYEE WELLNESS PROGRAMS ACT

To address this legal and regulatory uncertainty, Chairman Kline has introduced the Preserving Employee Wellness Programs Act of 2015 (H.R. 1189). (The measure has also been introduced in the Senate by Health, Education, Labor and Pensions Chairman Lamar Alexander (R-TN).)

The Council believes that H.R. 1189 supports the existing HIPAA and PPACA legislative framework with regard to wellness programs, striking the right balance between providing certainty to employers and ensuring an appropriate role for the EEOC to protect employees from discrimination.

Under The Preserving Employee Wellness Programs Act:

- Plans that comply with the wellness provisions of HIPAA that were amended by PPACA (included in Section 2705(j) of the Public Health Service Act) shall not violate the ADA or GINA by offering rewards in compliance with PHSA Section 2705(j). In general, this protection extends to health contingent wellness programs, including activity-only and outcome-based programs.
- Participatory programs shall receive the same protection if the reward is less than or equal to the maximum reward amounts applicable to health contingent wellness programs.
- The collection of information about the “manifested disease or disorder of a family member shall not be considered an unlawful acquisition of genetic information with respect to another family member participating in workplace wellness programs” and shall not violate GINA.

- The bill also includes two rules of construction. The first states nothing should be construed to limit the continued application of the *bona fide* benefit plan exception to wellness programs. The second rule of construction states that nothing “shall be construed to prevent an employer that is offering a wellness program to an employee from establishing a deadline of up to 180 days for employees to request and complete a reasonable alternative standard.”

The Council fully supports advancement of H.R. 1189 and urges members of the subcommittee and full committee to join Chairman Kline as cosponsors.

CONCLUSION

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 their employees and their family members.

The Council fully respects the EEOC’s existing and longstanding authority to implement and enforce the ADA, as well as other federal statutes. As the committee considers advancing H.R. 1189, we applaud you for recognizing 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.

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.

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.