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TESTIMONY OF
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WELLNESS PROGRAMS UNDER FEDERAL EQUAL OPPORTUNITY LAWS
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Good morning, Madame Chair, Commissioners. It is always a pleasure to be back before the Commission – but as always, more of a challenge to be sitting down here facing the tough questions, rather than up there posing them! That said, I would like to thank Chair Berrien, and Commissioner Lipnic, whom I understand have worked cooperatively to arrange this morning's meeting on an issue of great interest and import to employers, employees, advocates, and policymakers. I would like to use my limited time here this morning to highlight a few key points, and would ask that my full statement be included in the record of this morning's meeting. My testimony today is solely my own and I do not represent my firm, its clients or any organization with which I have affiliations.

The issue of wellness programs, and their treatment under various federal laws, as both a matter of health care policy, as well as a matter of non-discrimination law, has become an increasingly discussed topic among the range of interested stakeholders.
At the outset, let me make clear that I do not hold myself out this morning as a technical expert on the ins and outs of health benefit plans, and the myriad laws to which they are subject. Such experts are well-represented on this morning's panel, and I will defer to their technical expertise on these fine points. Rather, I am here this morning, as a management-side employment attorney, to raise a few of the host of questions I and my partners are hearing from our clients as they attempt to manage the issues surrounding rising health care costs, new federal health care structures, and the role of wellness programs in the workforce.

We must start with the premise that wellness programs as a component of employer-sponsored health insurance are here, and here to stay. A recent study conducted by the Society for Human Resource Management (SHRM), indicated that nearly nine out of ten (87%) respondents indicated that worksite wellness initiatives are beneficial.[1] Nearly all (96%) of these members agreed that the initiatives help workers develop healthier lifestyles. And the majority (84%) of organizations responding to the survey also agreed that worksite wellness initiatives lower health care costs and increase worker productivity.

Looking to the future, slightly more than one-half (55%) of SHRM's member organizations have a worksite wellness initiative for their employees. Of the

[1] *See* "SHRM Survey Findings: Workplace Wellness Initiatives" (December 2012), attached here to as Appendix A.

organizations that currently offer worksite wellness initiatives, 85 percent are interested in expanding or improving their current worksite wellness initiative in the next one to three years. For organizations that do not currently offer a worksite wellness initiative, 69 percent of them are very or somewhat interested in developing one in the next one to three years.[2]

Plainly then, from the employer/plan-sponsor perspective, wellness plans are viewed as an important tool in getting employees actively involved in the management of their own health, as well as in helping employers control the ever-increasing cost of providing health care to their workers. All available evidence suggests that the use of wellness programs in health care management will only continue to expand in the future, making the questions raised today all the more important.

The employer community is not alone in embracing the use of wellness plans as a tool to both improve health and control health care costs. Indeed, the signature achievement of the Obama Administration – the "Affordable Care Act" – prominently endorses the use of wellness plans. The Affordable Care Act codified and expanded the existing regulatory exemption for workplace wellness programs that include health-related standards,[3] and required that "wellness services and chronic disease management" be part of the core benefit package for health care plans offered through health care exchanges. Most recently, the Administration, through draft Affordable Care Act regulations, proposed to increase the amount by which health plans can vary their premiums for participation in workplace wellness plans, from 20 percent to 30 percent, and in some instances, as much as 50 percent. So the Administration's position in strong support of wellness programs within employer-sponsored health care, is pretty clear.

What is far less clear – and what is central to our discussion today – is what position the Commission will take with respect to these plans. In that light, I think most would agree

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[2] Moreover, recent studies of wellness programs such as a recent weight loss study conducted by the Mayo Clinic, have found that participants who received financial incentives were more likely to stick with a weight loss program and lost more weight than study participants who received no incentives. The Mayo study involved 100 healthy adult Mayo employees or their dependents, ages 18-63. *See* http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/Weight-Loss-Incentives.aspx

[3] On December 20, 2006, the Departments of Health and Human Services, Labor, and Treasury issued the final HIPAA nondiscrimination regulations. The 2006 Regulations addressed the permissibility of "standard-based wellness programs" under HIPAA's nondiscrimination provisions. A standard-based program is one that conditions eligibility for a reward on a participant's ability to meet a standard related to a health factor. Standard-based wellness or disease management programs are permissible under HIPAA only if they meet the following requirements: (1) the reward must be no more than 20 percent of the cost of coverage; (2) the program must be designed to promote health or prevent disease; (3) the program must give individuals an opportunity to qualify for the reward at least once a year; (4) the reward must be available to all similarly situated employees; and (5) the program must disclose that alternative standards or waivers are available. Each standard-based program offered by an employer must meet these five requirements independently of any other program that may be offered. In addition, when determining whether the 20 percent standard is satisfied for a particular design, the rewards offered under all of the employer's standard-based programs under the same plan must be aggregated and, together, must not exceed the 20 percent standard.

that the critical inquiry that a wellness plan is likely to generate for the Commission is whether it is "voluntary."[4]

Over the years, the EEOC's Office of Legal Counsel ("OLC") has issued a number of "Informal Discussion" letters[5] on employer-sponsored wellness programs. In the most recent letter, OLC reiterated the Commission's position on the question of voluntariness as such: "Disability-related inquiries and medical examinations are permitted as part of a voluntary wellness program. A wellness program is voluntary as long as an employer neither requires participation nor penalizes employees who do not participate." [6] Unfortunately, the agency has offered very little guidance to date as to what this "voluntary" standard means in practice. In previous opinion letters, OLC explained that an employer may not require an employee to complete an HRA as part of a wellness plan to participate in the employer's group health plan,[7] or to receive medical reimbursement from the employer's health reimbursement account.[8] The Commission has never adopted a formal position, and perhaps more important, apart from OLC informal letters setting out these far-end of the spectrum "don'ts," this agency has not offered any meaningful guidance as to the range of permissible spectrum "dos" with respect to financial incentives.[9]

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[4] Wellness programs typically involve disability-related inquiries and medical examinations. As a general rule, under the Americans with Disabilities Act ("ADA"), disability-related inquiries and medical examinations must be job-related and consistent with business necessity. To meet this standard, the employer must have a reasonable belief based on objective evidence that either (1) an employee's ability to perform an essential job function will be impaired by a medical condition, or (2) an employee will pose a direct threat due to a medical condition. The legal issue raised by wellness programs is that they typically are implemented "across the board" without regard to an employer's reasonable belief based on objective evidence. Therefore, most, if not all, programs would not meet the "job-related and consistent with business necessity" standard. The Commission recognized this issue and in 2000, the agency issued Guidance indicating that the ADA would also permit disability-related inquiries or medical examinations that are not job-related and consistent with business necessity provided that they are "voluntary." *See* EEOC Notice, "Enforcement Guidance on Disability-Related Inquiries and Medical Examinations under the Americans with Disabilities Act (ADA)" (No. 915.002, July 27, 2000).

[5] Informal Discussion letters are often referred to Advisory Opinion Letters. EEOC Commissioners neither vote on nor review these letters prior to their release.

[6] Peggy R. Mastroianni, Legal Counsel, U.S. Equal Employment Opportunity Commission, "Informal Discussion Letter," January 18, 2013, available at http://www.eeoc.gov/eeoc/foia/letters/2013/ada_wellness_programs.html (hereinafter, "EEOC January 18, 2013 Letter"); *See also* EEOC Notice, "Enforcement Guidance on Disability-Related Inquiries and Medical Examinations under the Americans with Disabilities Act (ADA)" (No. 915.002, July 27, 2000).

[7] Peggy R. Mastroianni, Associate Legal Counsel, U.S. Equal Employment Opportunity Commission, "Informal Discussion Letter," March 6, 2009, available at http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.

[8] Peggy R. Mastroianni, Associate Legal Counsel, U.S. Equal Employment Opportunity Commission, "Informal Discussion Letter," August 10, 2009, available at http://www.eeoc.gov/eeoc/foia/letters/2009/ada_health_risk_assessment.html.

[9] In its regulations interpreting the Genetic Information Non-Discrimination Act, the Commission identifies $150 as a permissible financial incentive for participation in a wellness program, but does not indicate whether such incentive is permissible under the ADA as well. *See* 29 CFR § 1635.8 (b)(2)(ii)(A) &(B); *id*. § 1635.8 (b)(2)(iii)(A).

Given this Administration's consensus,[10] the Commission's failure to provide meaningful guidance as to the level of financial incentive that can be provided as a condition of participation in wellness program before it is rendered involuntary has left employers and plan sponsors in a very grey – and dare I say frustrating - area. Indeed, the question we often hear from our clients is "if my plan is structured to comply with HIPAA and the Affordable Care Act requirements for wellness plans, will it be considered compliant for EEO purposes"? This is a question we should be able to answer with certitude and, for a brief period of time, we could. As you are aware in a January 2009, OLC opined that HIPAA compliance would be deemed to be ADA compliance. However, as you are also aware, that portion of that letter deeming compliance with HIPAA to be compliance with the ADA was withdrawn shortly thereafter, leaving employers with even greater uncertainty.

In light of the clear policy decision made by Congress in the Affordable Care Act – that wellness programs will not be found to discriminate on the basis of health factors when they provide financial incentives within certain specified limits and other protections including the alternative standards or waivers in the HIPAA regulations – there is a powerful argument to be made that the Commission should acknowledge this choice, and hold wellness plans to those same specified incentives. Put more simply, the Commission should articulate plainly a policy that compliance with the complex scheme contained within HIPPA and the Affordable Care Act will be compliance for purposes of federal EEO law.

A related question which the Commission has yet to answer specifically is whether and to what extent a wellness plan's financial participation incentive is a "carrot" or a "stick" carries any legal significance. As noted above, the Affordable Care Act proposed regulations generally provide that wellness plans may provide an incentive of up to 30% of the total cost coverage (or in some cases up to 50%). What our clients have asked – and what the Commission has yet to answer – is whether a wellness plan that offers a "reward" incentive for successful participation – say, a cash benefit, or a premium reduction – is materially different than a plan that penalizes non-participants by way of, for example, a surcharge. Thus far, the Commission has declined to take a position on "whether and to what extent a reward amounts to a requirement to participate, or whether withholding of the reward from non-participants constitutes a penalty, thus rendering the program involuntary." [11] If the Commission views the issue of reward versus penalty as bearing on the ultimate question of voluntariness, it should let employers know so that they can structure their plans accordingly.[12]

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[10] It has been over six years since the Departments of Labor, Health and Human Services and the Treasury jointly issued HIPAA regulations and three years since Congress passed the Affordable Care Act.

[11] *See* Peggy R. Mastroianni, Legal Counsel, U.S. Equal Employment Opportunity Commission, "Informal Discussion Letter," January 18, 2013.

[12] It is also worth noting here that in Mayo Clinic Weight Loss Study, discussed in footnote 2, even those participants in the incentive group who paid penalties for failing to meet their monthly weight-loss goal were more likely to continue their participation in the study than those in the non-incentive groups.

A final related question relating to "voluntary" incentives is whether and to what extent incentives for spousal participation in wellness programs are permissible under the Genetic Information Non-Discrimination Act. As the Commission is no doubt aware, there is significant consternation in the employer community about EEOC's position on this point, and I understand that others today will make the case for EEOC clarifying that spousal incentives are permissible "voluntary" incentives under GINA. Let me add this, while I understand the Commission's concerns given the statutory language, this agency has found its way to through similar issues in the past and I have no doubt that it can find a simple, workable, common sense solution here.

In conclusion, let me again thank each of you for your time and thoughtful consideration to the issues I and my fellow panelists will raise here this morning, and make one last observation. As a former Commissioner, the continued legitimacy and integrity of the Commission will always be something of utmost importance to me. Within the last few years, federal health care policy has been transformed dramatically, and a host of federal agencies and regulators have staked claims over their respective "pieces" of the health policy "pie." During this same period, the Commission has failed to articulate with specificity its position on a number of the important issues raised this morning. I am concerned that if the Commission fails to do so, or worse yet, adopts a position that is at odds with the rest of the Administration, the EEOC's credibility may suffer and its relevance in this important national debate may indeed be lost.

I thank you each again, and look forward to your questions.