Working Group on Employee Wellness Programs

June 19, 2015

Bernadette B. Wilson
Acting Executive Officer
Executive Secretariat
U.S. Equal Employment Opportunity Commission
131 M Street, NE
Washington, DC 20507

Re: **RIN 3046–AB01 (Amendments to Regulations under the Americans with Disabilities Act)**

Submitted Electronically: www.regulations.gov

Dear Ms. Wilson:

We write to the EEOC today regarding the proposed rule that would amend the regulations and interpretive guidance implementing Title I of the Americans with Disabilities Act (the "ADA") as they relate to employer wellness programs (the "proposed rule") as issued in the Federal Register (Vol. 80, No. 75) on April 20, 2015. We appreciate the EEOC taking the first step to bring greater clarity on the use of financial incentives in employee wellness programs and the opportunity to offer our comments and recommendations on the proposed rule.

The Population Health Alliance Working Group on Employee Wellness Programs (the "Working Group") is comprised of population health companies who care deeply about the health and well-being of the American workforce and who have deep experience in the utilization of financial incentives to encourage employees and their families to engage in healthy behaviors. The Working Group is comprised of the following Members: Hooper Holmes (http://www.hooperholmes.com/), Bravo Wellness (http://www.bravowell.com/), HealthFitness (http://healthfitness.com/), Quad/Graphics (Quad/Med: http://quadmedical.com/), Healthways (http://www.healthways.com/), Blue Cross Blue Shield of Tennessee (http://www.bcbst.com/), and Welltok (http://welltok.com/). Collectively, our members touch over 51 million lives through our wellness and fitness programs. Many of the members also participate in the Population Health Alliance (formerly known as the Care Continuum Alliance) (the "PHA"), a trade organization whose mission is to advance the principles of population health improvement so they become pillars of our health care system. Many of PHA's members have experience serving highly vulnerable populations including the aged, blind and disabled through commercial plans and through Medicaid and Medicare.

Over the years, the PHA has also gathered research, science and utilization outcomes for wellness programs that have helped guide policy decisions. One example of such research on this topic is "The Science of Wellness Programs: A Synopsis".[1]

As you know, the Centers for Disease Control and Prevention (the "CDC") estimates 86 million adults aged 20 years and older are pre-diabetic. We know obesity and a sedentary lifestyle are contributing factors. CDC also estimates that 42.1 million adults in the United States currently smoke cigarettes. Cigarette smoking is the leading cause of preventable disease and death in the United States, accounting for more than 480,000 deaths every year, or 1 of every 5 deaths. Furthermore, tobacco use is responsible for at least $96 billion per year in direct medical costs. Overall, physical inactivity, tobacco use, poor diet, overweight and obesity, and unmanaged stress and depression are major contributors to poor health and cost employers an average of $1,658/employee per year, or $225.8 billion annually.[2] These health risk factors and the significant health costs to treat them are what employers are facing across our country. If it were not for workplace wellness programs and the incentives to encourage their use, millions of Americans would not have access to programs that help to mitigate these health risks.

Congress, in an effort to ensure Americans have access to not only health coverage but just as important, health and wellness, passed Section 2705 of the Affordable Care Act (the "ACA") to encourage greater incentives for wellness programs. In fact, this was one of the few public bi-partisan provisions of the bill. Subsequent regulations issued by the Department of Health and Human Services, the Department of Treasury, and the Department of Labor (the "Tri-Agency") in 2013 worked in harmony with Section 2705 and provided clear guidance for employee wellness programs to grow. According to the Kaiser Family Foundation's Employer Health Benefits 2014 Annual Survey, 98% of large companies (200 or more workers) and 73% of smaller companies in the United States offered at least one wellness program in 2014, and more than 75% of U.S. employees now have access to such programs. According to the Sixth Annual Wellness in the Workplace Study conducted by the Optum Resource Center for Health and Well-being, 87% of employers are offering incentives to drive engagement in these programs.

With the growth of employee wellness programs over the years, it has been our experience that the most successful programs share some basic characteristics. To be successful, all levels of the company must have a commitment to creating a culture of wellness, an effective communications platform and access to the health and wellness opportunities. While successful wellness programs may vary in some of the services they offer, most typically include the following core components:

1) **Health Risk Assessments ("HRAs")** – Questionnaires, offered either on-line or by paper, that are used to provide employees with an evaluation of their health risks and quality of life. HRAs are then used to provide feedback from a health advisor or in the form of an

[1] http://www.populationhealthalliance.org/images/letters/WhitePapers/S700-071A%20The%20Science%20of%20Wellness%20Programs_A%20Synopsis_FINAL.pdf

[2] National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health

online report describing how to mitigate these identified risks. HRAs are one of the most utilized wellness program tools.

2) **Biometric Screenings** – Can be provided in multiple settings to include the worksite, employee's own home or during a health fair. These screenings may include: Height, Weight, Calculated Body Mass Index (the "BMI"), Waist Circumference, Blood Pressure, and Pulse Rate. Blood screenings are also offered at the worksite during a biometric screening or through the employee's personal physician, these include blood testing either through a finger stick or venipuncture to test for glucose, nicotine and cholesterol. Mouth swab (individual's saliva) or urine analysis may also be used for identifying nicotine or byproducts of nicotine for tobacco cessation programs.

3) **Lifestyle Modification Programs –** Offered telephonically, online, or on-site, these programs include tobacco cessation, weight management, health coaching, nutrition and diet, exercise, stress management, and workplace competitions.

4) **Educational Programs** – Health seminars and resources offered both on-site and on-line.

5) **Culture of Wellness** – Employer policies or practices designed to improve health such as tobacco bans, encouraging taking the stairs, bringing healthy foods to employee meetings and offering healthy foods in the cafeteria.[3]

HRAs and biometric screenings are central to helping employees identify risks that may signal an existing disease or the potential for a disease. In many cases, these screenings provide the first indication to an employee that they are at risk and need to seek medical attention or make a lifestyle change.

Studies indicate that financial incentives are essential to encourage behaviors such as completing a health assessment or biometric screening.[4] The three most popular incentive-based health improvement programs offered by employers in 2015 are:

1) Biometric screenings (72%)
2) HRAs (70%)
3) Physical activity programs (54%)[5]

Offering health improvement programs, and incentives to encourage their use, are critical to helping (i) employees address their health risks and (ii) employers manage the rising cost of

[3] "Biometric Health Screening for Employers" Consensus Statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, and Care Continuum Alliance (JOEM, Vol. 55, Number 10, October 2013).
[4] "Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives" Consensus Statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society, Cancer Action Network, American Diabetes Association, and American Heart Association (.JOEM, Volume 54, Number 7, July 2012)
[5] National Business Group on Health and Fidelity Investments 2014 Survey

healthcare. At the same time, it is also critical that these programs protect the rights of all Americans.

Section 2705 of the ACA and 2013 Tri-Agency regulations Employee Protections

As you know, Congress and the Tri-Agency implemented measures to protect the rights of employees who participate in incentive based wellness programs. The 2013 Tri-Agency regulations reiterated Congress' intent that regardless the type of wellness program, every individual participating should be able to receive the full amount of any incentive/reward, regardless of any health factor. To achieve this goal, "health-contingent" wellness programs that require the achievement of health outcomes (e.g., reduce BMI) must offer a 'reasonable alternative standard' (or waiver of the otherwise applicable standard) that allows the individual to earn the incentive through an alternative if it is not otherwise appropriate for the individual to achieve the outcome measure. Specifically, a reasonable alternative standard for obtaining the reward must be provided for any individual for whom, for that period, it is either unreasonably difficult due to a medical condition to meet the otherwise applicable standard, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard."[6] For example, if an individual has an eating disorder, under the ACA the individual has the ability to obtain a waiver or an alternative standard without any requirement for that physician to divulge the fact that the employee has an eating disorder or any other medical condition.

We understand the important role the EEOC plays in protecting Americans from discrimination and coercion through participation in a wellness program. We also recognize how important it is that the EEOC assist American workers in understanding their rights, how their information should be used in wellness programs, and how their privacy and confidentiality should be protected when participating in a workplace wellness program. We believe there are areas of your proposed rule that accomplish these goals, others that are consistent with the current ACA/Tri-Agency framework and other areas that can be improved to continue to strike the appropriate balance between encouraging participation in wellness programs and protecting workers. We have identified those provisions we believe should be adopted, and our recommendations for those that we believe should be modified to strike this balance:

I. Provisions that should be adopted

1) Prohibition on Retaliation or Adverse Action - Provisions of the proposed rule, except as otherwise permitted by the ADA, that would prohibit employers from 1) requiring employees to participate in the wellness program, 2) denying health coverage if an employee does not participate in the wellness program, or 3) taking any adverse employment action or taking any other coercive or threatening action against an employee who does not participate in the wellness program.

[6] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans. Federal Register/Vol. 78, No. 106

2) Use of Information – The proposed rule provides that medical information collected through an employee health program may only be shared with "covered entities" and business associates covered under HIPAA and may only be provided to an employer in aggregate terms that do not disclose the identity of the specific individual except as needed to administer the health plan.

3) Protected Health Information – The proposed rule provides that information collected or created from participants in a wellness program that is part of a group health plan should be treated as protected health information (PHI).

4) Required Notice – The proposed rule requires a notice that clearly explains what medical information will be obtained, who will receive the medical information, how the information will be used, the restrictions on its disclosure and the method the covered entity will employ to prevent the improper disclosure of the information. Offering further information to educate employees that the wellness program should 1) conform to the "voluntary" standards of the ADA and 2) offer the various protections on use of information as previously noted, aligns with principles already employed under the current ACA/Tri-Agency framework.

These four provisions conform to existing law and regulations which will help inform employees of their rights and educate employees about how wellness programs work.

II. Recommendations for greater clarity and consistency with the ACA/Tri-Agency Framework

1) Proposal to limit the fifty percent (50%) premium incentive cap for smoking cessation programs – On behalf of the Tri-Agency, the RAND Corporation analyzed the data base of the PHA. As cited in the Tri-Agency final regulation, "RAND found notable evidence of the effectiveness of smoking cessation programs in its analysis of the [PHA] database and case studies. The [PHA] database analysis found that participation in a program targeting smoking cessation decreases the smoking rate among participating smokers by 30% in the first year." The Tri-Agency regulation also recognized that employers, especially large ones, are adding incentives to their overall wellness programs and many were looking to strengthen their tobacco cessation programs. The enormous health and economic benefits to our society from helping people quit smoking is without question. This is why the Tri-Agency regulation permitted employers to offer up to 50% of premium incentives toward smoking cessation programs. [7] Typical wellness programs offer screenings for employees to test for cotinine (a byproduct of nicotine) and to verify

[7] Section 2705 of ACA: "The Secretaries of Labor, Health and Human Services and the Treasury may increase the reward under this subparagraph to up to 50 % of the cost of coverage if the Secretaries determine that such an increase is appropriate."

whether or not they are engaged in this unhealthy behavior. The proposed rule would treat these types of screenings as a medical examination under the ADA and subject it to a lower 30% cap. While other blood and saliva tests are designed to detect clinical risk factors such as high cholesterol or glucose, these tests along with others (i.e. urine analysis) can also help determine whether the employee is a tobacco user. To fairly administer incentivized tobacco cessation programs consistent with the ACA/Tri-Agency framework, employers should be able to accurately determine the tobacco status of their employees. Simply answering a question about tobacco use on a questionnaire would enable a tobacco using employee the opportunity to misrepresent their status in order to gain access to the incentive which would be unfair to employees who either do not use tobacco or are honest about their tobacco use and willing to participate in a cessation program.

Furthermore, Congress included a provision in the ACA that prohibits insurers from denying coverage based on factors such as health status. However, tobacco users can be charged up to 50% more for health insurance premiums than non-tobacco users in the individual or small group market.[8] Where permitted, some employers in the U.S. refuse to hire employees who smoke altogether. Our Working Group members offer wellness programs to all employees at the workplace and will try to help them quit this unhealthy and expensive habit through tobacco cessation programs. For some, they will get the 50% premium reduction for quitting and for allowing a test once a year. For others, they may be offered a reasonable alternative standard which allows them to achieve the 50% reduction in premium if they simply complete a tobacco cessation course regardless if they quit tobacco. Finally, if a physician determines that it would be medically inadvisable for an employee to participate in the tobacco cessation program, the employee would not have to participate in the program and the employee would still earn the incentive. We understand overcoming addiction may require a cycle of failure and renewed effort, and we believe the "reasonable alternative standard" such as tobacco education and nicotine replacement therapies as recommended in the Tri-Agency guidance provides a reasonable means for employees to obtain the financial incentive. If however, an employee who uses tobacco refuses to participate in the program or the alternative standard, our members believe it is unfair to subject employers to the potential high costs associated with this unhealthy behavior. The Tri-Agency regulations permit employers in these cases to include a penalty of up to 50% (when using screenings) and Congress allows insurers to charge a 50% surcharge for smokers as well. If wellness programs lose this ability, employers will likely re-consider their tobacco cessation programs and where permitted, simply not hire an employee who smokes.

Recommendation: The current 50 percent of the cost of coverage financial incentive for tobacco cessation should remain in place as it relates to all screenings for employees.

[8] 242 U.S.C. § 300gg(a)(1).

2) Provision counting "participatory programs" and "non-financial incentives" towards incentive caps – This approach would reverse years of guidance that wellness programs have been working under and have a significant impact on wellness designs. As you know, the ACA explicitly states that programs that are "participatory" do not fall under the financial cap established under the "health contingent" provisions. These participatory programs are defined as follows:

> (A) A program that reimburses all or part of the cost for memberships in a fitness center.
> (B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
> (C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).
> (D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.
> (E) A program that provides a reward to individuals for attending a periodic health education seminar.

If a medical inquiry or medical examination is offered through the wellness program, these types of participatory programs as proposed in the rule would be counted toward the incentive cap – an incentive that is quickly diminishing throughout the proposed rule. Previously, if an employer contributed $60 to the employee's health coverage and the employee contributed $40, the total cost would be $100 of which up to $30, or in some cases $50 for smoking cessation, could be used for a reward for a health–contingent standard. Under the new proposal, the employer's contribution to a gym membership would count towards the premium incentive cap and would de-value further incentives that could be offered to employees to encourage participation in health and wellness programs.

Furthermore, some wellness programs offer non-financial rewards to encourage participation in their wellness programs. For example, coffee-mugs, jean day, or a "day off" from work are sometimes offered as typical rewards. These types of rewards were again not envisioned by Congress or the Tri-Agency regulations to be counted against the incentive cap and it is difficult to imagine how the intangible rewards would be reasonably and fairly valued. Counting these items against the cap may have the effect of discouraging employers from providing these valuable incentives to employees.

Recommendation: This proposal runs counter to the current ACA/Tri-Agency framework. Participatory program incentives should not be counted towards the

incentive cap – only "health-contingent" program incentives should be counted. In addition, non-financial incentives should not be counted against the cap.

A more reasonable approach to consider could be the participatory program represented in the scenario below:

An employee is given a $100.00 surcharge on their health premium for failure to participate in their employer's wellness program (that includes either a medical inquiry or medical examination). This type of scenario could be considered for inclusion under the financial incentive cap and we would argue would not run afoul of the ACA/Tri-Agency framework.

3) Provision limiting the calculation of "cost of coverage" to employee only – Currently, the "cost of coverage" used for calculating the incentive limits under the ACA is the total of both employee and spouse/dependent cost of coverage when family members also participate in the wellness program. A recent Employer-Sponsored Health and Well-being survey found that for 2015, 54 percent of employers will offer incentives to spouses/domestic partners.[9] Increasingly, employers are embracing wellness as a family issue and studies show that allowing spouses to participate in the wellness programs doubled the rate of employee participation – from 14% to 28%. In addition, including spouses in key components of the program was linked with improvements in medical trends and health risk.[10] Limiting the cost of coverage calculation to the employee only would effectively cut the amount of allowable incentives in half. For example, if the total cost of employee plus spouse coverage was $10,000 each or a total of $20,000, an incentive value of 30% could differ between $6,000 (current ACA/Tri-Agency framework) or $3,000 (under proposed rules). As you know, Section 2705 of the ACA explicitly provides for participation by dependents: "the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (<u>or the employee and any dependents are</u>) receiving coverage." The expansion of the ADA into coverage of dependents is novel and could limit the wellness options provided to the employee's family.

Recommendation: The proposed rule should reflect prior authorization in the current ACA/Tri-Agency framework to include both employee and family member coverage and not further disrupt wellness program designs that have been abiding by the current framework.

4) Comments on written consent – The proposed rule poses the question of whether "a requirement that employees participating in wellness programs that include disability-

[9] http://www.businessgrouphealth.org/pub/29d50202-782b-cb6e-2763-a29a9426f589
[10] HERO Employee Health Management Best Practices Scorecard

related inquiries and/or medical examinations, and that are part of a group health plan, provide prior, written and knowing confirmation that their participation is voluntary? " We don't think a written consent form is in the best interest of the employee. If the wellness program is well designed and meets the guidelines the proposed rule would create, employees will participate. If coercive means are used to force participation, many employees would simply sign the consent form and this written consent form would not provide them with adequate protection.

Recommendation: A better approach to take than a written consent form is to ensure employees are made aware through the notice provision of the regulation as opposed to a new written consent requirement. Expanding the proposed notice requirement to include that 1) the employee's participation is voluntary, and 2) that the employee can seek an alternative standard or waiver, would be a more workable approach to prevent violations of the ADA.

5) Comments on including incentives in calculating the "affordability standard" - First, creating a new affordability standard as it relates to wellness program incentives was not envisioned by Congress when it passed Section 2705 of the ACA. This proposal could in essence make a wellness program "involuntary" based on the financial situations of individual employees on any given day and the cost of the plan the employee chooses. It also fails to recognize the potential lower cost of insurance an employee could achieve for participation in a reasonably designed wellness program as it relates to the affordability of the health plan the employee chooses. The ACA wanted to ensure employers continued to offer affordable health insurance to employees. However, if they are to provide qualified health care at a reasonable cost as required by the ACA, they should have the ability to offer wellness programs designed to improve health and reduce health costs.

Recommendation: We suggest the ACA already provides adequate safeguards to protect all Americans and that all Americans should have the opportunity to achieve lower premiums offered through wellness programs. Furthermore, we would argue the creation of a new "affordability standard" is outside the purview of the ADA.

6) Comments on Physician Attestation - Today, a program may say "complete a walking program and earn $100" or "Reduce your BMI by 5% and earn $20 per month off of your premium contribution" and an individual may go to their physician who indicates that the individual cannot complete the walking program because they have a medical issue that prevents them from doing so and the physician could recommend an alternative standard (swimming, exercise bike…) or a waiver of the standard altogether. Thus, for the BMI goal (being outcome based), there does not have to be a medical reason for the alternative, the physician could indicate that the goal is not advisable and request a waiver.

Recommendation: The ACA/Tri-Agency framework provides strong protections to employees to ensure reasonable accommodations are made for disabled Americans. Furthermore, if a health status (i.e. reducing BMI) makes it "medically inadvisable or unreasonably difficult" for a disabled individual to achieve, a statement from the individual's physician can be used for verification and the individual would be entitled to the financial incentive.

7) Wellness Program Offered Outside the Group Health Plan – We understand the EEOC welcomes comments on "What is a wellness program offered outside a group health plan?" We would suggest the following test questions could help answer this:

- Is the wellness program offered by a vendor that has contracted with the group health plan or insurer?
- Is the wellness program offered only to those enrolled in the group health plan coverage?
- Is the wellness program offered as part of the open enrollment process of the group health plan?
- Is the wellness program described as a covered benefit under the terms of the group health plan?

An example of a wellness program **offered outside the group health plan** is offered in the scenario below:

An employer contracts with a wellness vendor to offer a healthy eating program. This healthy eating program is available to all employees whether they participate in the employer- sponsored group health plan or not. This healthy eating program in our view is outside the group health plan.

An example of a wellness program offered **inside the group health plan** is offered in the scenario below:

Exclusively as a benefit of the employer-sponsored group health plan, employees covered under the plan who have certain medical conditions (e.g. hypertension) have access to a wellness vendor who provides condition management services. That program would be considered part of the group health plan.

8) Genetic Information Nondiscrimination Act (GINA) Proposed Rule and Effective Date of ADA Final Rule – We understand a Notice of Proposed Rulemaking from the EEOC for GINA is expected sometime in July of 2015. While we had hoped the GINA

issue could have been included in this proposed rule, we are encouraged the EEOC is attempting to address this remaining issue. As with the ADA expected final rule, the GINA final rule may require time for wellness programs to come into the safe harbor parameters the EEOC issues.

Recommendation: We respectfully request 1) the EEOC release the GINA final rule in conjunction with the ADA final rule to minimize the impact for compliance purposes and 2) allow sufficient time for wellness programs to come into compliance with both final rules. We would ask for your consideration in making the effective date of the final rule no earlier than the first day of the first plan year beginning twelve months after the issuance of the final rule.

The Population Health Alliance Working Group on Employee Wellness Programs appreciates the time and effort the EEOC has committed to bring greater clarity on the use of financial incentives in employee wellness programs. We understand the difficult task at hand to ensure all Americans under the ADA are treated fairly and are protected from discriminatory acts. We strive to see all Americans have an opportunity to achieve health and wellness and look forward to working with you to produce a final rule that will make the general public more knowledgeable about wellness programs and the benefits that can be achieved.

Sincerely,

Christobel Selecky
Chair of the PHA

Shane Doucet
on behalf of the PHA Working Group

PHA Working Group Members:
Bravo Wellness
Quad/Graphics
Hooper Holmes
HealthFitness
Welltok
Healthways
Blue Cross Blue Shield of Tennessee