



AMERICAN BENEFITS

COUNCIL

TESTIMONY OF

**ALLISON R. KLAUSNER,
PRINCIPAL, GOVERNMENT RELATIONS LEADER
KNOWLEDGE RESOURCE CENTER
CONDUENT HUMAN RESOURCE SERVICES**

ON BEHALF OF THE

AMERICAN BENEFITS COUNCIL

BEFORE THE

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

**HEARING ON "LEGISLATIVE PROPOSALS TO IMPROVE HEALTH
CARE COVERAGE AND PROVIDE LOWER COSTS FOR FAMILIES"**

MARCH 1, 2017

My name is Allison Klausner, and I am a Principal and Government Relations Leader of the Knowledge Resource Center at Conduent Human Resource Services. I am testifying today on behalf of the American Benefits Council (the “Council”), of which Conduent is a member. I am also the Chair of the Council’s Policy Board of Directors.

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 and their families enjoy healthier and more productive lives.

As stated in the Council’s public policy strategic plan, [*A 2020 Vision: Flexibility and the Future of Employee Benefits*](#),¹ employer-sponsored benefit plans are designed with the express purpose of giving each employee the opportunity to achieve personal health and financial well-being. This well-being serves as the foundation for employees to achieve optimal performance and productivity and, in turn, drives successful organizations.

The Council has asked me to testify on its behalf because, in my role as Principal and Government Relations Leader at Conduent’s Knowledge Resource Center, I have extensive experience helping my organization and its employer clients understand and navigate important legislative and regulatory developments related to employee benefits, including wellness programs. In my role at Conduent, I not only have significant exposure to the innovative wellness programs that employers are developing for their employees, but I also have great insight into the chilling effects that recent regulatory developments in the wellness field continue to have on employer sponsorship of wellness programs. In addition, in my prior role as Assistant General Counsel at Honeywell International Inc., I experienced firsthand the difficulties that can arise for employers and their employees when there is a lack of consistent federal policy on important issues such as employer-sponsored wellness 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 recognized the important role of wellness programs as a cornerstone of health reform.

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

As I will discuss today, the future of workplace wellness programs remains at risk. Despite explicit Congressional support of wellness programs in recent years (for example, through PPACA's codification of the HIPAA framework), employers continue to face complex and inconsistent regulations for the design and administration of these programs, most recently as the result of regulations relating to wellness programs finalized by the U.S. Equal Employment Opportunity Commission ("EEOC").

The Council's 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, the EEOC's recently finalized rules, which address the application of Title II of the Genetic Information Nondiscrimination Act ("GINA") and Title I of the Americans with Disabilities Act ("ADA") to wellness programs, are not consistent with the well-established and employee-protective wellness program regulatory framework under HIPAA.

The result is that many wellness programs already subject to regulation under HIPAA may now also be subject to incongruent and competing regulations under Title II of GINA and the ADA. In addition, many wellness programs that are not subject to HIPAA, but which are highly beneficial – such as healthy mother/healthy baby and diabetes management programs – may now be subject to rules so burdensome that employees may lose access to these programs where employers conclude they are no longer able to offer such programs.

My testimony will describe the current state of employer-sponsored wellness programs and how they benefit employees. Not only are these programs important for achieving better health outcomes for employees and their families, 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 Conduent's 2016 survey report, *Working Well: A Global Survey of Workplace Wellbeing Strategies*,² which represents the views of 428 employer respondents based in 33 countries, including 187 respondents in the United States alone.

I will also explain how the inconsistent and unnecessarily complex federal regulatory landscape is adversely affecting employers' wellness initiatives. I will close with suggestions for how the Committee may be able to alleviate the problem as it considers any future legislation.

² Conduent Human Resource Services, *Working Well: A Global Survey of Workforce Wellbeing Strategies* (2016).

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 Conduent, 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 programs designed to support behavioral changes, such as tobacco cessation.

Wellness 2.0 incorporates rapid adoption of health risk appraisals and biometric screenings to assess the health of the covered population. These more advanced approaches are increasingly integrated with employee assistance programs (“EAPs”)⁴ and/or disease management programs, often leveraging portals and tracking of incentives with appropriate privacy and security safeguards. 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. 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.

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 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).

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, but 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 Conduent 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)
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
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

Some wellness program designs include a reward or incentive element to encourage participation in wellness programs, increase overall participation, and inspire employees to strive for healthy results. Ninety percent of U.S. employers with wellness programs responding to the Conduent survey currently offer incentives, including rewards, penalties, or both, to encourage participation in wellness initiatives. The most common activities for which incentives are offered include the completion of a health risk appraisal or biometric screening, or participation in tobacco cessation programs or workplace health "challenges" (such as walking).

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 increased 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-plan premiums or deductibles.⁵

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 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).⁶

A company's wellness strategy is dictated not only by its choice of programs but also by its participant scope. Our survey found that 69 percent of programs include spouses, 56 percent include domestic partners and 42 percent include children. Our survey also found that 23 percent of responding firms offer wellness programs to their retirees.

Additionally, as suggested in the Council's 2015 testimony⁷ 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 made with the goal to improve employee well-being, increase productivity and lower

⁵ Michael P. O'Donnell, Should Employees Get Insurance Discounts for Completing Wellness Programs?, *Wall Street Journal*, Feb. 18, 2013, at R5.

⁶ Aon Hewitt, 2012 Health Care Survey (2012).

⁷ See <http://www.help.senate.gov/imo/media/doc/Baase2.pdf>.

long-term health costs.

While “improving performance and productivity” is cited as the most important wellness program objective to U.S. employers (with 83 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.

The potential for cost savings is particularly appealing to U.S. employers, with 76 percent of respondents in the United States telling Conduent that “reducing health care or insurance costs” is “very important” or “extremely important.” While measurement is still inconsistent even among program sponsors, 24 percent of employers told us that their wellness program had an impact on their population’s health care trend rate, and 67 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.⁸ Although the effective date of the tax is delayed until 2020, employers continue to model its impact on their plans and consider and implement changes to health benefits coverage to help avoid the tax.

A RAND Employer Survey⁹ 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,¹⁰ with reductions in inpatient costs accounting for 62 percent of the total cost reduction, compared to outpatient costs (28 percent) and prescription drug costs.¹¹

The available evidence also supports the aspirational goals of wellness programs – like improving productivity, morale and safety. Data from the RAND survey shows 78 percent of responding employers stated that their wellness program has decreased absenteeism and 80 percent stated that it has increased productivity.¹² Likewise, 32 percent of respondents to a 2014 Mercer Survey said specifically that the health risks of

⁸ Code section 4980I imposes a 40 percent excise tax on “applicable employer-sponsored coverage” offered to 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).

⁹ RAND, Workplace Wellness Programs Study: Final Report (2013).

¹⁰ Id at 53.

¹¹ Id at 57.

¹² Id at 53.

the population served by their wellness programs were improving.¹³

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).¹⁴ According to our data, 45 percent of responding employers were measuring specific outcomes from health promotion programs in 2016.

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 grow.

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. As part of our 2014 study, we asked employers whether they had a wellness strategy. A full 65 percent of U.S. respondents indicated that they do have a wellness strategy. This 65 percent included 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,¹⁵ SHRM¹⁶ and The Families and Work Institute.¹⁷

The trend is particularly strong among large employers. According to the Kaiser Family Foundation's Employer Health Benefits 2016 Annual Survey,¹⁸ 83 percent of large U.S. companies (with 200 or more workers), compared to 46 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 (42 percent vs. 14 percent).¹⁹

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

¹³ Mercer, Taking health management to a new level (2014) via Sloan Center, *supra* note 2, at 3.

¹⁴ RAND, *supra* note 10 at 61.

¹⁵ Willis, The Willis Health and Productivity Survey Report (2015).

¹⁶ SHRM, State of Employee Benefits in the Workplace – Wellness Initiatives (2013).

¹⁷ Matos, K., & Galinsky, E., Families and Work Institute, 2014 National Study of Employers (2014).

¹⁸ Kaiser Family Foundation, Employer Health Benefits 2016 Annual Survey – Health Risk Assessments, Biometric Screening and Wellness Programs 224 (2016).

¹⁹ *Id* at 225.

wellness programs.²⁰

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 to design these programs.

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 HIPAA. PPACA's bipartisan provision increased employer flexibility in designing programs to improve the health of employees and their families and reinforced wellness programs as a cornerstone of health reform.

A critical component of encouraging employers to offer meaningful wellness programs for the benefit of employees and their families is consistent federal policy with respect to the regulation of wellness programs. We appreciate the work of this Committee in introducing H.R. 1189, Preserving Employee Wellness Programs Act ("Act"). The Act included important clarification that wellness programs that comply with HIPAA and the PPACA would not violate the ADA or GINA merely by offering a reward – a step toward consistent federal policy.

Following the 2015 introduction of the Act, the EEOC issued regulations under Title II of GINA and the ADA governing wellness plans, which are inconsistent with HIPAA. The unnecessary burdens imposed on employers by multiple incongruent regulatory structures stifle adoption and innovation of wellness programs. We are concerned the future of workplace wellness programs is at risk. We encourage the Committee to consider approaches for alleviating these unnecessary regulatory burdens in any future legislation. We look forward to working with the Committee to achieve a consistent federal regulatory scheme for workplace wellness programs.

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

²⁰ Sloan Center on Aging & Work at Boston College, Fact Sheet 38: Health and Wellness Programs in the Workplace 1 (July 2014).

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”)²¹ 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, disability.²² 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.²³

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

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

²² See Code § 9802(a)-(b). Code § 9802(a)(1) identifies the following as health factors: (i) disability, (ii) health status, (iii) medical condition (including both physical and mental illnesses), (iv) claims experience, (v) receipt of health care, (vi) medical history, (vii) genetic information, and (viii) evidence of insurability (including conditions arising out of acts of domestic violence).

²³ Code § 9802(b)(2).

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

²⁵ See 26 C.F.R. § 54.9802-1(f)(2). Examples of participatory wellness programs include reimbursement of gym memberships, diagnostic testing that does not condition receipt of a 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.

satisfy the HIPAA nondiscrimination rules.²⁶

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 permits regulators to increase incentives up to 50 percent at their discretion). This is a rare bipartisan provision in the otherwise 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.”²⁷ These final wellness rules are based on the same general framework as the 2007 HIPAA wellness rules. They only apply to wellness programs that are offered in connection with, or that are themselves, group health plans.

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 as long as any reward is available to all similarly situated individuals. 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,

²⁶ See 26 C.F.R. § 54.9802-1(f)(3)-(4). Examples include not smoking, attainment of certain biometric screening results, and achieving exercise targets.

²⁷ 78 Fed. Reg. 33,158.

with different requirements for each depending on the type of program.

The HIPAA wellness program regulations promulgated pursuant to PPACA require that health-contingent programs satisfy a number of new requirements. Health-contingent programs must limit the maximum incentive to 30% of the total cost of coverage (up to 50% for tobacco cessation programs). The limit is based on the total cost of employee-only coverage (or enrolled coverage if dependents may participate). The regulations also enhanced protections for participants by requiring that health-contingent programs must make available a reasonable alternative standard in certain situations where an individual cannot satisfy the initial standard. In addition, the regulations require a notice alerting individuals to the availability of a reasonable alternative standard.

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 the Federal Register on October 7, 2009.²⁸ 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

²⁸ Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. 51,664 (Oct. 7, 2009).

with enrollment, or at any time for underwriting purposes.²⁹

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.³⁰ 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.³¹ “Genetic information” is defined for purposes of GINA Title I to include family medical history.³²

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).³³ A plan or issuer can provide rewards for completing an HRA as long as the HRA does not collect genetic information.

Title II: Title II of GINA, which is under EEOC’s jurisdiction, restricts how employers may collect and disclose genetic information and prohibits employers from using genetic information in employment decisions. Final regulations under Title II were published in the Federal Register on November 9, 2010.³⁴

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:

²⁹ Id.

³⁰ Code § 9832(d)(10).

³¹ 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).

³² 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).

³³ Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. at 51,669.

³⁴ Regulations Under the Genetic Information Nondiscrimination Act of 2008, 75 Fed. Reg. 68,912 (Nov. 9, 2010).

- 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).³⁵

The 2010 regulations raised questions as to whether incentives could be offered to spouses for completing HRAs that request health information. This is because, when an employer requests information from an employee's spouse about the spouse's current or past health status, this request itself may be considered a request for the employee's genetic information (i.e., an inquiry regarding the manifestation of a disease or disorder in a family member). This is due to the fact that GINA and the 2010 regulations define "genetic information" by reference to a "family member," which is defined to include an individual's spouse.

In May 2016, the EEOC finalized regulations addressing the question of spousal HRAs.³⁶ The 2016 GINA regulations provide that an employer may offer an incentive to an employee as part of an ADA-compliant employee health program in exchange for an employee's spouse providing information about the spouse's manifestation of disease or disorder as part of an HRA or biometric screening administered in connection with an employer-sponsored wellness program. The maximum total incentive is limited to 30% of the total cost of employee self-only coverage (as opposed to enrolled coverage, as is the case with HIPAA where a dependent participates in a wellness program). Notably, incentives may not be offered for a child's provision of this information (unlike under HIPAA). The EEOC rules also require that the spouse provide prior knowing, voluntary, and written authorization when the spouse is providing information regarding his or her own manifestation of disease or disorder.

³⁵ 29 C.F.R. §1635.8(b)(2).

³⁶ Genetic Information Nondiscrimination Act, 81 Fed. Reg. 31,143 (May 17, 2016).

The 2016 GINA regulations apply to wellness programs regardless of whether they are part of a group health plan (unlike HIPAA, which is limited to wellness programs that are part of a group health plan).

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.³⁷ 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.³⁸

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. Until the issuance of proposed and final regulations in 2015 and 2016, respectively, there was little guidance regarding what the term “voluntary” means in this context.

In May 2016, the EEOC also finalized regulations addressing what constitutes a “voluntary” wellness program for purposes of the ADA.³⁹ The 2016 ADA regulations provide that an employer may offer an incentive to an employee in connection with a medical examination or a disability related inquiry where offered as part of an employee health program. The maximum total inducement is limited to 30% of the total cost of employee self-only coverage (as opposed to enrolled coverage, as is the case with HIPAA where a dependent participates in a wellness program).

In addition to HIPAA’s existing notice requirements, the final EEOC regulations require the use of a much more prescriptive and lengthy notice, which must be provided to employees in advance of their participation in an ADA-subject wellness program. Additionally, the 2016 ADA regulations provide that a “voluntary” wellness program cannot – based upon program participation – deny coverage under any group health plan or particular benefits package within a group health plan, or otherwise limit the extent of medical benefits or services.⁴⁰ Accordingly, wellness programs subject to the ADA cannot encourage wellness program participation by tying access to special or additional group health plan coverage or benefits packages to wellness program participation.

³⁷ 42 U.S.C. § 12112(a).

³⁸ 42 U.S.C. § 12112(d).

³⁹ Regulations Under the Americans With Disabilities Act, 81 Fed. Reg. 31,126 (May 17, 2016).

⁴⁰ See 81 Fed. Reg. at 31,139.

Another important misalignment in the regulatory schemes is that the 2016 ADA regulations apply to wellness programs regardless of whether they are part of a group health plan. This is unlike HIPAA, which applies solely to wellness programs that are part of a group health plan.

Additionally, and quite importantly, many employers now sponsor wellness programs with a disease management component. Under these programs, individuals with a health factor may be provided financial incentives to engage with the wellness program – but at all times they must be treated better than similarly situated employees who lack the health factor. Many employers sponsor disease management programs under this rubric, such as healthy mother/healthy baby programs, or diabetes management programs. One example is that a plan may charge a copay for the purchase of insulin, but may waive the copay for their enrollees with diabetes given the clinical evidence supporting the importance of properly managing blood sugar levels.

While these programs are excepted from HIPAA’s prescriptive regime – which is appropriate given the favorable treatment under these programs of persons with an adverse health status – the 2016 ADA regulations could subject these types of disease management programs to the regulations’ requirements, which, as discussed below, would likely cause many employers to reconsider offering these very valuable and helpful programs.

KEY CONCERNS FOR EMPLOYERS

Notwithstanding the important role of wellness programs in promoting the health and productivity of employees and their families, the inconsistent federal regulatory framework under HIPAA, GINA, and the ADA has caused many employers to take a step back or pause in their implementation of innovative wellness programs. This is because the new rules under GINA and the ADA added complexity and inconsistency and have made it significantly more difficult for employers to structure programs that comply with all applicable federal regulatory regimes.

The Council’s *A 2020 Vision* strategic plan, urged that “federal agencies promulgating regulations should proceed in a consistent, collaborative manner that supports participatory and outcomes-based wellness initiatives.” We are concerned that the recent final EEOC regulations under GINA and the ADA have resulted in more inconsistency, not less. Programs that are subject to comprehensive and robust regulation under HIPAA nonetheless are now also subject to a different – and sometimes conflicting – framework under GINA and the ADA. Moreover, effective programs that previously were subject to minimal regulation – such as healthy mother/healthy baby programs and participatory disease management programs – are now subject to unnecessarily burdensome rules that will cause some employers to

consider whether to continue them.

Because federal regulations are not aligned in a consistent manner, they have put at risk the availability and effectiveness of workplace wellness programs. This would have the adverse consequence of depriving employees and their families of the meaningful wellness benefits that such programs offer, including improved health and productivity.

POLICY RECOMMENDATIONS

We urge the Committee to consider the issues discussed above and identify solutions aimed at bringing greater consistency to federal regulation of wellness programs and reducing unnecessary burden.

The Council encourages the Committee to consider the following in the development of any future legislation:

- Wellness programs that are subject to, and comply with, the wellness provisions of HIPAA (as amended by PPACA) should be deemed to comply with the ADA and GINA Titles I and II, respectively, if they offer rewards that comply with the limits imposed on health-contingent programs under HIPAA. It would minimize unnecessary regulatory burden on wellness programs and ensure that employers are able to rely on Congress's prior stated support for HIPAA-compliant wellness programming.
- Wellness programs that are not subject to the wellness provisions of HIPAA (as amended by PPACA) should be deemed to comply with the ADA and GINA Titles I and II if they offer rewards that comply with the limits imposed on health-contingent programs under HIPAA. In general, this would apply to wellness programs that are not offered as part of, or in connection with, an employer group health plan, but which voluntarily comply with HIPAA's incentive limits for health-contingent programs.
- Wellness programs that provide for more favorable treatment of individuals with adverse health factors (i.e., disease management programs that are excepted from HIPAA) should be deemed to comply with the ADA and GINA Titles I and II.
- The collection of information about the "manifested disease or disorder of a family member" should not be considered an unlawful acquisition of genetic information with respect to another family member as part of workplace wellness programs and should not violate GINA. This provision, if enacted,

would ensure that employers can offer to an employee's spouse or child the same opportunities afforded to the employee to earn incentives in connection with undertaking activities to better understand or manage his or her current health status and related health risks.

CONCLUSION

It is my hope that this testimony has reinforced the imperative to support and strengthen the efforts of employers to be effective in their role of advancing the health and well-being of their employees and their family members.

As the Committee considers any future legislation, we urge you to do so with the goal of achieving consistent federal policy and a regulatory framework that is minimally burdensome while protecting individuals from discrimination. We believe that framework exists in the current HIPAA regulations implemented under PPACA.

The employer community appreciates this Committee's recognition of the importance of wellness programs and the existing regulatory framework that protects individuals against unlawful discrimination, 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 employee the opportunity to achieve personal health and financial well-being. This well-being serves as the foundation for employees to achieve optimal performance and productivity, which, in turn, drives successful organizations.

Thank you for your interest in employer-sponsored wellness programs. I appreciate the opportunity to testify, and look forward to working with you to create a consistent federal policy for employer-sponsored wellness programs to improve the health and productivity of employees and their families.