INNOVATIONS IN HEALTH CARE: EXPLORING FREE–MARKET SOLUTIONS FOR A HEALTHY WORKFORCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

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C O N T E N T S

INNOVATIONS IN HEALTH CARE: EXPLORING FREE–MARKET SOLUTIONS FOR A HEALTHY WORKFORCE

Thursday, April 14, 2016
U.S. House of Representatives
Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
Washington, D.C.

The Subcommittee met, pursuant to call, at 10:30 a.m., in room 2176, Rayburn House Office Building. Hon. David P. Roe [chairman of the subcommittee] presiding.

Present: Representatives Roe, Walberg, Salmon, Guthrie, Messer, Carter, Grothman, Allen, Polis, Courtney, Pocan, Hinojosa, Bonamici, and Takano.

Also Present: Representatives Kline and Scott.

Staff Present: Bethany Aronhalt, Press Secretary; Andrew Banducci, Workforce Policy Counsel; Janelle Belland, Coalitions and Members Services Coordinator; Ed Gilroy, Director of Workforce Policy; Callie Harman, Legislative Assistant; Christie Herman, Professional Staff Member; Nancy Locke, Chief Clerk; Dominique McKay, Deputy Press Secretary; Michelle Neblett, Professional Staff Member; Brian Newell, Communications Director; Krisann Pearce, General Counsel; Alissa Strawcutter, Deputy Clerk; Juliane Sullivan, Staff Director; Olivia Voslow, Staff Assistant; Joseph Wheeler, Professional Staff Member, Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Austin Barbera, Minority Press Assistant; Pierce Blue, Minority Labor Detailee; Denise Forte, Minority Staff Director; Christine Godinez, Minority Staff Assistant; Carolyn Hughes, Minority Senior Labor Policy Advisor; Eunice Ikene, Minority Labor Policy Associate; Brian Kennedy, Minority General Counsel; Veronique Pluviose, Minority Civil Rights Counsel; and Elizabeth Watson, Minority Director of Labor Policy.

Chairman ROE. A quorum being present, the Subcommittee on Health, Employment, Labor, and Pensions will come to order. Good morning, everyone. I want to welcome our witnesses. We appreciate you joining us today for an important conversation on health care and the future of employer-sponsored coverage.

This hearing furthers the goals of the Task Force on Health Care Reform which was established to develop a plan to replace

ObamaCare's one-size-fits-all with free-market, patient-centered solutions.

We have already held a number of meetings to take input from members, policy experts, and stakeholders, and to build consensus around policies that will deliver the results the American people want and deserve.

Our vision is clear. It is time to modernize our health care system so we can empower every American with affordable coverage, provide more choice, promote quality for all patients, and strengthen health care security for retirees.

Finally, as we will discuss today, we want to encourage innovation and harness the power of new technologies in order to foster lower prices and better treatment for patients.

As a physician with more than 30 years of experience, I have personally seen the need for common sense reforms to strengthen our health care system, a system that is too costly and bureaucratic. As an elected official, I am constantly hearing from families who are struggling to access the care they need or keep up with their premiums that rise year, after year, after year.

Unfortunately, the President's government takeover of health care is making these problems worse. Health care costs are going up, not down. Americans are seeing higher premiums. Families are losing access to the coverage they like and the doctors they trust. Small business owners are being forced to choose between providing costly government-approved health insurance and hiring new workers as they have struggled to navigate a web of burdensome mandates and regulatory requirements.

Just to give you an example, the city where I was mayor, Johnson City, Tennessee, had to hire a person to navigate all this so they could figure out whether they were complying with the law or not, a city with a fairly extensive HR department.

The American people cannot afford this fundamentally flawed law, and that is why House Republicans are determined to deliver meaningful reform. We have a responsibility to put our health care system on a better course, one that is patient-centered, not government driven.

As part of that effort, we need to understand the vital importance of employer-sponsored coverage, which insures roughly 155 million Americans, and take a closer look at what is being done in the private sector to improve care.

Employers have played a critical role in driving health care innovation. Despite unprecedented uncertainty in the health insurance market and drastic changes in employer-sponsored coverage, employers of all sizes are still developing creative strategies to help control costs and meet the changing needs of the workforce.

These strategies include wellness programs, which are now an essential tool to help control costs and encourage healthy lifestyles. The Kaiser Family Foundation reported in 2015 that 50 percent of employers offering health benefits also offer wellness programs.

That same year, I joined Chairmen Kline and Walberg in introducing legislation that would eliminate regulatory hurdles to implementing these programs, and I look forward to hearing from experts today on how we can make that goal a reality.

Some employers have responded to costly mandates and rigid reporting requirements under current law by putting in place private exchanges. This, too, will reign in costs through competition, and unlike public exchanges, serve individuals, and both large and small employers.

Accountable care organizations are another concept employers have adopted in recent years to improve the health of their employees and make coverage more affordable. ACOs improve patient experience by coordinating their care between doctors and hospitals and focusing on prevention and management of chronic disease.

Employers are also incorporating telemedicine into their health insurance plans, providing patients more access to care at lower costs and much greater convenience.

We are here today to examine how innovations in employer-provided coverage are improving health care for workers and their families, and how Federal policies can support rather than discourage free-market solutions.

I hope our conversation will bring us one step closer to achieving responsible reforms the American people desperately need.

With that, I will now recognize the ranking member of this subcommittee, Chairman Polis, for his opening remarks. You are recognized.

[The statement of Chairman Roe follows:]

Prepared Statement of Hon. David P. Roe, Chairman, Subcommittee on Health, Employment, Labor, and Pensions

This hearing furthers the goals of the Task Force on Health Care Reform, which was established to develop a plan to replace ObamaCare's one-size-fits-all approach with free-market, patient-centered solutions. We've already held a number of meetings to take input from members, policy experts, and stakeholders, and to build consensus around policies that will deliver the results the American people deserve.

Our vision is clear: It's time to modernize our health care system so we can empower every American with affordable coverage, provide more choice, promote quality care for all patients, and strengthen health care security for retirees. Finally, as we will discuss today, we want to encourage innovation and harness the power of new technologies in order to foster lower prices and better treatment for patients.

As a physician with more than 30 years of experience, I've personally seen the need for commonsense reforms to strengthen our health care system, a system that is too costly and bureaucratic. As an elected official, I constantly hear from families who are struggling to access the care they need or keep up with premiums that rise year after year.

Unfortunately, the president's government takeover of health care is making these problems worse. Health care costs are going up, not down. Americans are seeing higher premiums and a lower quality of care. Families are losing access to the coverage they like and the doctors they trust. Small business owners are being forced to choose between providing costly, government-approved health insurance and hiring new workers, and they're struggling to navigate a web of burdensome mandates and regulatory requirements.

The American people cannot afford this fundamentally flawed law, and that's why House Republicans are determined to deliver meaningful reform. We have a responsibility to put our health care system on a better course—one that is patient-centered, not government-driven. As part of that effort, we need to understand the vital importance of employer-sponsored coverage—which insures roughly 155 million Americans—and take a closer look at what's being done in the private sector to improve care.

Employers have played a critical role in driving health care innovation. Despite unprecedented uncertainty in the health insurance market and drastic changes in employer-sponsored coverage, employers of all sizes are still developing creative strategies to help control costs and meet the changing needs of the workforce.

These strategies include employee wellness programs, which are now an essential tool to help control costs and encourage healthy lifestyles. The Kaiser Family Foun-

dation reported in 2015 that 50 percent of employers offering health benefits also offer wellness programs. That same year, I joined Chairmen Kline and Walberg and introduced legislation that would eliminate regulatory hurdles to implementing these programs, and I look forward to hearing from experts today on how we can make that goal a reality.

Some employers have responded to costly mandates and rigid reporting requirements under current law by putting in place private exchanges. This tool helps rein in costs through competition, and unlike public exchanges, serves individuals and both large and small employers. Accountable Care Organizations are another concept employers have adopted in recent years to improve the health of their employees and make coverage more affordable. ACOs improve the patient experience by coordinating care between doctors and hospitals and focusing on prevention and management of chronic diseases. Employers are also incorporating telemedicine into their health insurance plans, providing patients more access to care at lower costs and greater convenience.

We are here today to examine how innovations in employer-provided coverage are improving health care for workers and their families and how federal policies can support—rather than discourage—free-market solutions. I hope our conversation will bring us one step closer to achieving the responsible reforms the American people desperately need.

Mr. POLIS. Thank you. You referred to me as "Chairman Polis." I do not know if we are expecting a change or not. Ranking Member Polis and someday chair, perhaps.

But I want to thank the chairman for convening this. This is a great conversation. I think we are all interested in the role of employers, the role of wellness. The discussion that has occurred in Congress and will continue to really runs the gamut from should employers even be involved with the provision of health care to what can employers do to encourage wellness among employees and share in the benefits of reduced costs that can accrue from the right kinds of wellness programs.

I was in Congress when we passed the Affordable Care Act. I remember various predictions that occurred, many of them were about many employers dropping health care coverage or skyrocketing costs. I am glad to say that many of those doomsday predictions have not occurred.

Of course, we can find instances of employers who made decisions to drop, employers that made decisions to add health care, but in the aggregate, for better or worse, there has not been a market shift from the employer-based system of health care.

In fact, there has been a delay in the tax provisions that would have encouraged that shift to occur, namely a tax referred to as the "Cadillac tax," which I think was in part designed to transition from an employer-based health care system to an individual or exchange-based health care system.

I have started several businesses myself as an employer before the ACA. I knew how frustrating health care costs were. Health care choices were difficult, expensive for small businesses. The administrative burden to small businesses it was and is large. I certainly think anything we can do through the exchanges to reduce the administrative burden of administering health care programs for small- and mid-sized businesses would be greatly beneficial.

The fact is that receiving health care through an employer is still the most popular option. In my own state, the proportion of Coloradoans with large employer coverage is actually increasing, and it increased about 3 percent over the last five years, and currently 156 million Americans are covered by their employers.

The ACA made a number of changes to improve access to insurance. I think it is a baseline of having insured more than 10 million people, 10 million more people that we can build upon. I think we are also very interested in cost reduction measures. Wellness initiatives can certainly be among those.

Last fall, as an example, my State legislature in Colorado passed a law allowing physicians to write prescriptions using remote telemedicine technology. In instances like that, examples like that can be used to reduce costs.

Additionally, we can share findings on things to reduce costs through the Division of Insurance and use data in pursuit of more innovative solutions to control costs. I think that will be the key with regard to measuring the effectiveness of wellness programs at employers.

There is a lot of hype, and we really have to see what actually accrues in cost savings, to the shared benefit, one would hope, of the employee and the company that offers the wellness program with, of course, room for private contractors to make a profit as well who actually provide those types of wellness programs.

I hope that we can find a better, more streamlined way to deliver care. It is also important that we do not forget the importance of policies like paid sick leave and paid family leave that are very important to employees and important to overall wellness and job satisfaction.

Remind, I want to use this occasion to remind our chair that over 40 million workers do not have access to paid sick days and paid family leave, which I think are really helpful and the basis of some of the important wellness policies that we need to initiate.

I look forward to hearing from our witnesses, look forward to a thoughtful discussion about how we can control health care costs through innovative partnerships between the government and the private sector, and hearing a little bit more about the role of employer-based health care now and in the future, and I yield back the balance of my time.

[The statement of Ranking Member Polis follows:]

Prepared Statement of Hon. Jared Polis, Subcommittee on Health, Employment, Labor, and Pensions

I thank the chairman for yielding to me, and I thank all of our witnesses for providing us with their time and expertise this morning.

Since the passage of the Affordable Care Act in 2010, over 20 million uninsured Americans have gained access to health coverage.

In Colorado, 15.8 percent of folks in our state lacked insurance before the ACA. Last year that number fell to 6.7 percent, a historic low.

The ACA is working, despite some flaws, and this is largely due to a shared push by individuals, federal and state governments, and employers to increase coverage nationwide.

I was in Congress when we passed the ACA, and I remember the doomsday predictions that were being thrown around at the time, about workers losing coverage or about costs skyrocketing.

But thankfully, many employers have stepped up to the plate and the pundits have been proven wrong.

I have started several businesses myself. And as an employer I know that before ACA, health care costs were climbing at an out-of-control rate for employers and employees. Health care choices were slim to none in many states, and people had to choose health insurance over strategic career moves when considering job opportunities.

The six years since the ACA has been implemented have not always been perfect, but premiums are down and choices are up for employees and businesses.

In fact, ACA has lowered costs and spread the responsibility among everyone – both employers and employees. Before the passage of the ACA, the annual premium increase for employer-sponsored family insurance hovered at 9.5%. By 2015 it had fallen to 2.7%.

The fact is that receiving health insurance through your employer is still a really popular option for many people. In my home state, the proportion of Coloradans with large-employer coverage is actually increasing, growing by 3.5 % over the past two years. Currently, 156 million Americans are currently covered by their workplace.

In a tightening job market, health insurance benefits are one way that employers can attract top talent. I don't see how the ACA dampened that fact.

Furthermore, under the ACA, employer-sponsored insurance plans are required to be more comprehensive. And everyone benefits from the coverage of preventive services without cost sharing, such as free access to flu shots or mammograms.

The ACA improved access to insurance, and we must move forward from that baseline. We cannot return to a time when these basic health services were not guaranteed.

Of course, we can always do better. As members of Congress, we have a responsibility to improve upon the model of health insurance we put in place six years ago, and to support innovations that may produce healthier outcomes for Americans across the country.

I am proud to say that my home state of Colorado is leading the way in terms of collaboration to bend the cost curve of health care.

Last fall, the state legislature passed a law allowing physicians to write prescriptions using remote telemedicine technology. Not only does this boost convenience by saving an employee a trip to the doctor during work hours, telemedicine can actually lower costs. Certain insurers have started allowing calls or emails directly between a patient and physician, which ends up being less expensive than a full visit. I am enthusiastic about the ways that technology can empower consumers with information, support, and near-immediate access to care.

Colorado has also been doing some fascinating work in health care data transparency. We were one of the earliest states to adopt an all-payer claims database. The Center for Improving Value in Health Care (CIVHC:: pronounced "civic") has a mandate from the Governor to collect and analyze claims from both private and public payers.

They track how Coloradans are spending their health care dollars, and share this information with the general public. Workers deserve full disclosure when it comes to health insurance, it's certainly a common request I hear from constituents who call my office with questions about their premiums. Organizations such as CIVHC are playing an important role in educating people about their options.

Additionally, they also share these findings with researchers and the Division of Insurance, who use this data in pursuit of more innovative solutions to control costs and provide higher quality care. This type of collaboration is precisely the kind of partnership that we should see more of.

I personally recognize the ability of the private sector to redesign outdated models with an agility that Congress simply does not have. For health outcomes, this is particularly valuable.

I would issue a request, however, that in this insatiable hunt to find a newer, more streamlined way to deliver care, we don't forget the value of evergreen policies such as paid sick days and paid family leave. These relatively simple investments have been linked to healthier employees, higher rates of job satisfaction and lower turnover overall, but currently, 40 million workers don't have access to them.

I look forward to hearing from our witnesses, and discussing ways that we might be able to control health care costs through innovative partnerships between the government and the private sector.

Chairman ROE. I thank the gentleman for yielding. Pursuant to Committee Rule 7(c), all subcommittee members will be permitted to submit written statements to be included in the permanent hearing record. Without objection, the hearing record will remain open for 14 days to allow statements, questions for the record, and other extraneous material referenced during the hearing to be submitted into the official hearing record.

It is now my pleasure to introduce our distinguished panel of witnesses. First, Ms. Amy McDonough, who is the vice president and general manager of Corporate Wellness at Fitbit in San Francisco, California. She works with employers and partners in corporate wellness, supplying businesses with the tools to effectively engage employees in corporate wellness programs. You have a fun job, I think. Welcome.

Mr. John Zern is the executive vice president and global health leader with Aon in Chicago, Illinois. Mr. Zern is responsible for the strategic direction, client satisfaction, revenue growth, and operational and professional standards of Aon's health business. Welcome.

Ms. Sabrina Corlette, J.D., is the senior research professor at the Center on Health Insurance Reforms with Georgetown University's Health Policy Institute here in Washington, D.C. Ms. Corlette directs research on health insurance reform issues and has published many papers regarding the regulation of private health insurance and the development of health insurance marketplaces under PPACA. Welcome.

Ms. Tresia Franklin is the director of Total Rewards and Employee Relations at Hallmark Cards, Inc. in Kansas City. I think there is not anybody in here that has not used your product.

Ms. Franklin oversees Hallmark's compensation and benefit programs, human resource information systems, and employee relations. Welcome to Washington.

I will now ask our witnesses to stand and raise your right hands.

[Witnesses sworn.]

Chairman ROE. Let the record reflect that the witnesses answered in the affirmative, and you may take your seats.

Before I recognize your testimony, let me briefly explain our lighting system. You have five minutes to present your testimony. When you begin, the light in front of you will turn green. With one minute left, it will turn yellow. When your time has expired, the light will turn red. At that point, I will ask you to wrap up your remarks as best as possible, and members will have five minutes also to ask questions.

We will begin with Ms. McDonough for five minutes. You are recognized.

TESTIMONY OF AMY McDONOUGH, VICE PRESIDENT AND GENERAL MANAGER OF CORPORATE WELLNESS, FITBIT, SAN FRANCISCO, CA

Ms. MCDONOUGH. Thank you, Chairman Roe and Ranking Member Polis, for the opportunity to testify at today's hearing. As the fifth member of Fitbit, Inc., and vice president and general manager of Fitbit Wellness, I come today to share my passion for innovating around engaging data driven health solutions for employers.

Fitbit Wellness, our offering for corporate wellness, was born in 2010 in response to market-stated need. We are driven by a belief that the right data, tools, and guidance can empower people to take charge of their health and fitness, and that community is key to fostering healthy behavior.

With six years of experience behind us, we remain deeply committed to helping companies innovate in this space. We have a spe-

cific vision of wellness, one that addresses the diverse needs of both organizations and the people that power them.

The fundamental goal of any wellness program should be to provide opportunities for individuals to improve their health and wellness. The need for wellness programs has never been greater, and employers are uniquely positioned to improve population health by starting right in the workplace. Wellness should always be inclusive, voluntary, and should protect the privacy of the people it is aiming to serve.

While the use of our technology in the corporate wellness setting continues to evolve rapidly, the results our customers have seen so far are significant. Let me briefly share a few examples.

Indiana University Health, Indiana's most comprehensive health care system, has been a Fitbit Wellness customer for more than two years. They found that 40 percent of participants decreased their BMI and 60 percent of program participants with diabetes decreased their A1C levels.

For one of our other customers, BP, who we work with through a partnership with StayWell, Fitbit data was a factor in reducing their overall health care spending by 3.5 percent. BP also saw that for employees who participated in a lifestyle management program over a one year period, their health risks declined by 11.1 percent.

Appirio, another Fitbit Wellness customer, cut its 2015 insurance premiums by 6 percent, a savings of $280,000, after showing its insurer data about engagement with their wellness program, including aggregate data from the 400 Fitbit devices it had provided to its employees.

Fitbit Wellness is built around the understanding that better people-oriented technology enables stronger results. We focus on engaging people first, incentivizing health and wellness through rewarding community driven experiences using wearable devices that consumers love.

Companies have traditionally worried about investing in wellness due to lack of participation. Traditional wellness programs generally show about an average 24 percent participation rate. Fitbit Wellness' participation rates vary from company to company, but are often much higher, sometimes more than 80 percent.

Across industries, we are seeing results that point to the very real ways that wellness works to keep employees healthy, reduce health care costs, and increase productivity. When workplaces make the healthy choice, the easy choice, health outcomes are profound.

Employers are uniquely positioned to improve population health in the workplace by fostering wellness initiatives that are inclusive, fun, voluntary, and protect the privacy of the people they aim to serve.

Corporate wellness is evolving as we speak, and is increasingly seeking to represent a more holistic picture of what influences health. Wellness professionals are beginning to look beyond tradition measures, like diet and exercise, to everything from sleep and mental health to financial wellness and stress management. Wellness programs aim to help people live healthier, happier, and more active lives.

Inherent in that mission is the responsibility to implement appropriate data security and privacy policies. As the leader in the connected health and fitness market, Fitbit is committed to protecting user data and ensuring that the health information tools people turn to for help are used properly.

Fitbit believes that participation in wellness programs should always be voluntary. Employees should be given the choice to opt in to participate and there should be no penalties for abstaining from participating in a program.

Companies should provide participants with an understanding of how their data will be used. However, the regulations governing wellness programs are not always clear, and this confusion has left some employers on the sidelines.

We at Fitbit are supportive of efforts to clarify and streamline the applicable laws and regulations that govern the structure of wellness programs.

Thank you for inviting me to participate and to share Fitbit's passion for data-driven, community-oriented health solutions.

[The statement of Ms. McDonough follows:]

Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce

Written Testimony Provided to the
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and the Workforce
United States House of Representatives

Amy McDonough, Fitbit Inc.
April 14, 2016

Thank you Chairman Roe and Ranking Member Polis for the opportunity to testify at today's hearing. As the fifth team member of Fitbit Inc. and Vice President and General Manager of Fitbit Wellness, I come today to share my passion for innovating around engaging, data-driven health solutions for employers.

Today, I want to share with you:

- How wellness programs are working, and why these initiatives are so necessary.
- The need for innovative, data-driven approaches in this space, and how Fitbit Wellness is filling that role.
- How workplace wellness is evolving and barriers to widespread adoption.

Fitbit Wellness, our offering for corporate wellness programs, was born out of response to market-stated need. After Fitbit was founded in 2007, we soon noticed a trend of employers purchasing activity trackers in bulk for their employees. We recognized early on that there was a significant opportunity to help organizations develop and implement thoughtful wellness programs by utilizing data and consumer-oriented technology and services. Historically, we have found that wellness programs are expensive and often met with low employee participation,[1] while program administrators often lack the tools needed to implement programs efficiently and measure the efficacy of their efforts.[2]

Driven by a belief that the right data, tools and guidance can empower people to take charge of their health and fitness, and an enduring philosophy that community is key to fostering healthy behavior, Fitbit Wellness was born in 2010. In 2014, we launched software for companies to provide them with a global view on the activity trends in their populations, and additional tools to help implement Fitbit as a part of their wellness programs. Once we combined the power of the Fitbit ecosystem and brand with an employer-centered approach, we knew we had something great.

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[1] "Boosting Wellness Participation Without Breaking the Bank." Towers Watson. July 2010. Accessed via: https://www.towerswatson.com/en-US/Insights/Newsletters/Americas/insider/2010/boosting-wellness-participation-without-breaking-the-bank

[2] "CEOs Make Wellness at Work a Priority for 2016." Fitbit Wellness. March 2016. Accessed via: https://blog.fitbit.com/your-boss-cares-about-your-health-and-happiness-really/

With six years of experience behind us, we remain deeply committed to helping companies innovate in this space. We have a specific vision of wellness, one that addresses the diverse needs of both organizations and the people that power them. The fundamental goal of any wellness program should be to provide opportunities for individuals to improve their health and wellness. The need for wellness programs has never been greater, and employers are uniquely positioned to improve population health by starting right in the workplace. Wellness should always be inclusive, voluntary, and should protect the privacy of the people it is aimed to serve.

Fitbit Wellness works with employers to help improve the health and livelihood of their employee populations. Our employer partners include 70 of the Fortune 500, including Bank of America, Target, Barclays, McKesson and Kimberly-Clark. We also partner with leading brands such as Autodesk, Box, BP, Emory University & Emory Healthcare, Geico, GNC, Houston Methodist, Quicken Loans, Sharp Healthcare, Sutter Health and TransUnion. We also partner with leading wellness vendors such as Vitality, StayWell, and Virgin Pulse and health plans such as Premera Blue Cross, Optum/United and Anthem.

While the use of our technology in the corporate wellness setting continues to evolve rapidly, the results our customers have seen so far are significant. Let me briefly share a few examples:

- For one of our customers, **BP**, who we work with through a partnership with StayWell, Fitbit data was a factor in reducing their overall healthcare spend by 3.5 percent. BP also saw that for employees who participated in a lifestyle management program over a one-year period, health risks declined by 11.1 percent.[3]
- **Appirio**, another Fitbit Wellness customer, cut its 2015 insurance premiums by six percent (a savings of $280,000) after showing its insurer data about engagement with their wellness program, including aggregate data from the 400 Fitbit devices it had provided to employees.
- **Indiana University Health**, Indiana's most comprehensive healthcare system, has been a Fitbit Wellness customer for over two years. They've found that 40% of participants decreased their BMI, and 60% of program participants with diabetes decreased their A1C levels.

Fitbit Wellness is built around the understanding that better, people-oriented technology enables stronger results. We focus on engaging people first – incentivizing health and wellness through rewarding, community-driven experiences using wearable devices that consumers love. We develop scalable solutions that provide measurable

[3] StayWell/BP case study: http://staywell.com/wp-content/uploads/2014/01/StayWell-BP-CaseStudy_Jan2014.pdf

outcomes. Fitbit's simple, trackable wellness metrics enable employees to monitor and celebrate progress.

Companies have traditionally worried about investing in wellness due to lack of participation. Traditional wellness programs generally show about an average 24 percent participation rate.[4] Fitbit Wellness's participation rates vary company to company, but are often much higher – sometimes more than 80 percent.[5]

This is all about making personal health and fitness data relevant and actionable to the individual. Individuals are able to make better decisions about their health, and this has the potential to drive better health outcomes. Health interventions in a web-based format have been found to be more than twice as effective[6] in increasing exercise time, knowledge of nutritional status, and in weight loss treatment than those that are analog.

We are seeing results from across the industry that point to the very real ways that wellness works to improve health.

HumanaVitality recently released the results of a three-year study,[7] showing that employees engaged with health incentive programs had fewer unscheduled absences, lower overall health claims costs and fewer visits to the hospital and emergency room.

One study[8] by doctors Richard Milani and Carl Lavie found that 57 percent of high health risk program participants were converted to low-risk status by the end of a six-month wellness program. Even more, they found that every dollar invested in intervention yielded $6 in health care savings.

When Ohio's Regional Transit Authority saw their healthcare premiums increase by $360 per employee, they decided to invest in Fitbit Wellness. They launched their pilot program in 2014. After the one-year pilot, biometric screenings of program participants showed that total cholesterol had dropped by an average of 17 points; HDL had increased by an average of four points; and glucose levels had decreased by an average of 12 points. Three participants' glucose levels dropped 100 points or more, and one employee with Type 2 diabetes said he was able to stop taking Metformin by walking

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[4] "Workplace Wellness Programs Study." RAND Corporation. 2013. Accessed via: http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.sum.pdf

[5] Fitbit Wellness Customer Data. Fitbit, Inc.

[6] "The Effectiveness of Web-Based vs. Non-Web-Based Interventions: A Meta-Analysis of Behavioral Change Outcomes." Journal of Medical Internet Research. October 2004. Accessed via: http://www.jmir.org/2004/4/e40/

[7] http://humana.newshq.businesswire.com/press-release/current-releases/three-year-study-shows-engagement-wellness-program-lowers-health-clai

[8] "Impact of Worksite Wellness Intervention on Cardiac Risk Factors and One-Year Health Care Costs." The American Journal of Cardiology. November 2009. Accessed via: http://www.ajconline.org/article/S0002-9149(09)01337-X/abstract?cc=y=

more.

At Bank of America, 90 percent of employees were less stressed and 60 percent felt more connected to their colleagues after participating in their activity challenge. Moreover, Bank of America has begun to bend the trend in productivity and doctor visits as program participants decreased in risk of chronic illness, with 21.8 percent of employees migrating to a lower-health risk category from 2013 to 2015.[9]

Wellness programs can return decreased health risk, reduced medical costs and increased productivity,[10] and the benefits for organizations that make wellness a part of their culture are even greater.

Our current landscape is one of rising healthcare costs[11] and changing consumer lifestyles met by an increased focus on driving better workplace cultures and increasing employee engagement.[12] Employer-sponsored insurance is a tremendous part of this equation. According to Kaiser Family Foundation data, 147 million Americans, over half of the non-elderly population, are covered by their employers.

Employers are uniquely positioned to improve population health in the workplace by fostering wellness initiatives that are inclusive, fun, voluntary, and protect the privacy of the people they aim to serve. At present, 85 percent of employers with more than 1,000 employees offer a wellness program, and the numbers are on the rise for both large and small organizations.[13]

What's more is that there is an inherent connection between the workplace and the health of our nation. Working adults, on average, spend at least a quarter to a third of their waking hours on the job and will spend the majority of their lives at work. Our own Fitbit data shows that total sedentary time increases rapidly upon entering the workforce – by about an hour between ages 20 and 24. Sedentary time continues to rise over the course of our careers, by about 30 minutes from ages 24 to 30, and another 30

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[9] "Getting to the Root of a Healthier Workforce." Bank of America Presentation at Fitbit Captivate 2015. October 2015.

[10] "An Employer's Guide to Behavioral Health Services." National Business Group on Health. December 2005. Accessed via: http://www.businessgrouphealth.org/pub/f3139c4c-2354-d714-512d-355c09ddcbc4

[11] Institute of Medicine of the National Academies. Accessed via: http://resources.iom.edu/widgets/vsrt/healthcare-waste.html?utm_medium=etmail&utm_source=Institute%20of%20Medicine&utm_campaign=09.11+IOM+News&utm_content=IOM%20Newsletter&utm_term=Media

[12] "2015 Survey of Employers and Survey of US Health Care Consumers." Deloitte. Accessed via: http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/employers-still-bullish-on-wellness-programs.html?id=us:2em:3na:wellness:awa:chs:011116

[13] "Workplace Wellness Programs Study 2012." RAND Health, 2013. Accessed via: http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.sum.pdf

minutes from ages 30 to 55. We see a big drop-off in total sedentary time once people hit retirement age.[14]

There is a large body of research that paints a compelling picture of how work influences wellbeing: long hours and stress have been tied to everything from increased long-term risk of cardiovascular disease and diabetes to an accelerated aging process and decreased longevity. Eighty-three percent of workers say they're stressed about their jobs and 50 percent say stress is interfering with their sleep – that accounts for an estimated 80 percent of doctors' visits and at least 120,000 deaths each year.

When workplaces make the healthy choice the easy choice, health outcomes can be even more profound. Corporate wellness is evolving as we speak, and is increasingly seeking to represent a more holistic picture of what influences health. Wellness professionals are beginning to look beyond traditional measures like diet and exercise to everything from sleep and mental health to financial wellness and stress management.

The National Business Group on Health (NBGH) expanded their parameters for best-in-class wellness this year – the first update since 2005. In 2016, companies are integrating wellness into the fiber of their organizations, with the recognition that social connectedness, job satisfaction, emotional health, financial security, community involvement and so much more inform health status and behavior. Wellness programs must be able to track and provide results for metrics associated with health and wellbeing, speaking to the rise of wearable technology in the workplace. An ABI Research study from 2013 found that over the next five years, 13 million wearable devices embedded with wireless connectivity would be integrated into wellness plans offered by businesses. ABI Research also predicted in 2014 that by 2019, the enterprise wearable device market will reach $18 billion.[15]

The Wellness Council of America (WELCOA) identifies seven benchmarks for successful, purposeful wellness programs.[16] These include collecting data to drive health efforts, choosing appropriate interventions, creating a supportive environment and carefully evaluating outcomes. Just as our friends in the medical and scientific communities know, data, program design and evaluation are the foundation of any successful health initiative. With wellness programs' level of reach and access, though, comes great responsibility.

Wellness programs aim to help people live healthier, happier and more active lives. Inherent in that mission is the responsibility to implement appropriate data security and

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[14] "Fitbit User Sedentary Times." Fitbit, Inc. Internal Study Data. 2016.
[15] Wearable Wireless Devices in Enterprise Wellness Programs". ABI Research, 2013. Accessed via: https://www.abiresearch.com/market-research/product/1015937-wearable-wireless-devices-in-enterprise-we/
[16] "WELCOA's Seven Benchmarks." WELCOA. Accessed via: https://www.welcoa.org/services/build/welcoas-seven-benchmarks/

privacy policies. As the leader in the connected health and fitness market, Fitbit is committed to protecting user data and ensuring that the health information tools people turn to for help are used properly. Fitbit believes that participation in wellness programs should always be voluntary. Employees should be given the choice to opt-in to participate, and there should be no penalties for abstaining from participating in a program. Companies should provide participants with an understanding of how their data will be used. Our Wellness Community Pledge, which is publicly available, articulates our standards regarding program participation, data usage, compliance and incentives.

Unfortunately, the regulations governing wellness programs are not always clear and this confusion has left some employers on the sidelines. We at Fitbit are supportive of efforts to clarify and streamline the applicable laws and regulations that govern the structure of wellness programs.

Thank you for inviting me to share Fitbit's passion for data-driven, community-oriented health solutions. We are grateful for the opportunity to testify at today's hearing and look forward to a continued dialogue on the importance of wellness in employer sponsored coverage.

Chairman ROE. Typical of Fitbit, you finished right on time. Perfect.

Ms. MCDONOUGH. Thank you.

Chairman ROE. Mr. Zern, you are recognized for five minutes.

TESTIMONY OF JOHN ZERN, EXECUTIVE VICE PRESIDENT AND GLOBAL HEALTH LEADER, AON, CHICAGO, IL

Mr. ZERN. Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify at this important hearing on the value proposition that employer-sponsored coverage brings to our Nation's health care system.

More than 150 million Americans receive their health coverage through their employer.

Facing an increasingly diverse workforce and employees' desire for greater choice and control over their health care, employers are creating a more consumer driven experience for their employees, arming them with the right balance of tools, resources, and incentives to improve their health and their choices, along with the guidance, advocacy, and support needed for those individuals with serious and ongoing medical needs.

Aon is a leading global provider of risk and human services solutions. We serve over 5,000 employers in the U.S., and we administer benefits for over 10 million employees and retirees.

Employers are looking for new and innovative ways to change the way health benefits are offered. These programs include wellness, new technology, innovative delivery systems, private exchanges, and greater transparency in the cost and quality of health care services.

While we have experience in these and other types of new and innovative programs that employers are offering, today I will focus the discussion on one program in particular, Aon's development of a private health exchange. Employers face a significant challenge today of providing quality, affordable health coverage for employees in our complex health care system.

Employers are focused on promoting consumer engagement, reducing health care spending, and continuing to ensure that employees and their families have comprehensive coverage.

Our 2016 health care survey reveals that employers support the value proposition of offering health benefits to their employees, and only 5 percent of employers say they will stop offering health benefits in the next three to five years.

But, healthcare costs continue to rise at rates higher than CPI. Employers are evaluating better solutions that empower consumers with more choices in their health plan and benefit offerings. A private health exchange is a competitive retail-based, Web-enabled marketplace offering employer-sponsored group coverage.

Aon gives employers the ability to offer benefits through a private health exchange. These private health exchanges combine cost accountability with meaningful choice. The employer remains a vital part of the health care delivery system. Employers continue employer-sponsored coverage, pay the employer premium for the group, and remain subject to ERISA.

Employers determine how much of the coverage costs to subsidize, and employees use this subsidy to choose from a menu of

plans and insurance providers that best fit their needs and their financial situation.

Employees select among varying out-of-pocket differences and network requirements. It is a win-win for employer-based sponsored coverage and for employees who have the ability to select a plan that meets their needs and the needs of their families.

What we have learned is that most employees will select a plan based on their physician and provider network, their experience with that insurance carrier, the coverage of prescription drugs, and then price.

Many employers that currently offer their medical benefits through the Aon Active Health Exchange are also pursuing other workplace programs that encourage greater well-being and management of chronic illnesses.

Employers using the private exchange experienced a 3.3 percent cost increase for 2016, compared to an average health care cost increase of 5.5 to 6.5 percent.

We appreciate talking about private health exchanges as one way to maintain affordable employer-sponsored health coverage and expand the role of consumers in health care decision-making. We are also eager to help employers find other innovative ways to engage their employees, and we urge the Committee to support these efforts.

Rising costs, recent market shifts, and health care reform are challenges to maintaining coverage for Americans. Employers are the key to the success and need flexibility in the design and management of their benefit plans. They need congressional support to preserve and enhance the value of benefit plans offered to their employees and their families.

Thank you for permitting me the opportunity to testify today. I will submit for the record more comprehensive information about the development and growth of private health exchanges and other innovations that employers are adopting to engage their employees and their families.

Thank you.

[The statement of Mr. Zern follows:]

Oral Testimony
on behalf of Aon

By John Zern
Executive Vice President and Global Health Leader
Aon

Before

U.S. House of Representatives
Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor and Pensions

Hearing entitled

"Innovations in Health Care: Exploring Free-Market Solutions
for a Healthy Workforce"
April 14, 2016

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to testify at this important hearing on the value proposition that employer-sponsored coverage brings to our nation's health care system. More than 175 million Americans receive their health coverage through their employer. Facing an increasingly diverse workforce and employees' desire for greater choice and control over their health care, employers are creating a more consumer-driven experience for their employees—arming them with the right balance of tools, resources and incentives to improve their health and their choices, along with the guidance, advocacy and support needed for those individuals with serious and ongoing medical needs.

Aon is a leading global provider of risk management, insurance and reinsurance brokerage, and human resources solutions. We help public and private employers identify new strategies in offering health and retirement benefits. In the U.S. alone, we serve nearly 5,000 employers and employees across all 50 states. We administer health benefits for 350 employers representing more than 10 million employees and retirees.

Employers are looking for new and innovative ways to change the way health benefits are offered, and they are looking to help employees lower their risks of rising health care costs and increasing financial volatility. These new programs include wellness programs, new technology, innovative delivery systems, private exchanges and greater transparency in the cost and quality of health care services.

While we have experience in these and other types of new innovative programs that employers are offering, today I will focus the discussion on one program in particular—Aon's development of a **private health exchange**, which enables employees to select their choice of health care coverage.

Private Health Exchanges and the Consumerism Movement

Employers face the significant challenge today of providing quality, affordable health coverage for employees in our complex health care system. There are changes in how health care is delivered and paid for and these often vary from market to market. Employers that have employees in multiple states face the difficult task of determining how to offer innovative solutions in different health care marketplaces.

Employers are focused on promoting consumer engagement, reducing health care spending and continuing to ensure that employees and their families have comprehensive coverage. Our 2016 Health Care survey reveals that employers support the value proposition of offering health benefits to their employees, and only 5 percent of employers say they will stop offering health benefits in the next three-to-five years.

But health care costs continue to rise at a rate higher than CPI, and shifting costs to employees through increased out-of-pocket payments, limits on benefit offerings and higher coinsurance is not a sustainable approach. Employers are evaluating better solutions that empower consumers with more choices in their health plan and benefit offerings. A private health exchange is a competitive, retail-based, web-enabled marketplace offering employer-sponsored group coverage.

Aon gives employers the ability to offer benefits through a private health exchange. Private health exchanges combine cost-accountability with meaningful choice. The employer remains a vital part of the health care delivery system. Employers continue employer-sponsored coverage, pay the employer premium for the group health plan and remain subject to ERISA.

Employers determine how much of the coverage costs to subsidize, and employees use this subsidy to choose from a menu of plans and insurance providers that best fit their health and financial needs.

Employees select among varying out-of-pocket differences and network requirements. It is a win-win for employer-sponsored coverage and for employees who have the ability to select a plan that meets their needs and the needs of their families.

What we have learned is that most employees will select a plan based on the physician and hospital network, their prior experience with that insurance carrier, the coverage of prescription drugs and price.

The private health exchange offers employees real choice within a retail-shopping experience. Employers have the power to enhance the value of the benefits offered to their employees.

Many employers that currently offer their medical benefits through the Aon Active Health Exchange are also pursuing other workplace programs that encourage greater wellbeing and management of chronic illnesses. Employers using the private exchange experienced a 3.3 percent cost increase for 2016, compared to an average health care cost increase of 5.5 percent to 6.5 percent.

Policies That Support Innovations by Employers

We appreciate talking about private health exchanges, such as the Aon Active Health Exchange, as one way to maintain affordable employer-sponsored health coverage and expand the role of consumers in health care decision making. We are proud of these efforts. We also are eager to help employers find other innovative ways to engage their employees, and we urge the Committee to support these efforts.

Rising costs, recent market shifts and health care reform are challenges to maintaining coverage for Americans. Employers are the key to the success and need flexibility in the design and management of their benefit plans. They need Congressional support to preserve and enhance the value of benefit plans offered to their employees and their families.

Conclusion

Thank you for permitting me the opportunity to testify today. I will also submit for the Record more comprehensive information about the development and growth of private health exchanges and other innovations that employers are adopting to engage their employees and their families.

Chairman ROE. Thank you, Mr. Zern. Ms. Corlette, you are recognized for five minutes.

TESTIMONY OF SABRINA CORLETTE, SENIOR RESEARCH PROFESSOR, CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN UNIVERSITY'S HEALTH POLICY INSTITUTE, WASHINGTON, D.C.

Ms. CORLETTE. Thank you, Chairman Roe and Ranking Member Polis, for inviting me to participate in today's hearing.

As has been said, over 150 million Americans receive their health coverage through their employer. It is consistently rated as one of the most popular benefits that employers provide, second only to paid leave.

In my testimony today, I would like to emphasize two primary points. Number one, our foundation of ESI is strong in this country, but affordability remains a challenge. Number two, to address affordability, requires a multi-stakeholder effort that actively engages in local delivery system reform efforts.

In spite of early fears, the ACA has not caused employers to drop coverage for their workers, nor has it resulted in reductions in employment. What is clear is that employers have benefitted over the last few years in a significant slowdown in health care price growth.

But even with these promising trends, affordability remains a huge challenge for too many families. Worker contributions to premiums grew an estimated 83 percent between 2005 and 2015, and nearly one-quarter of people with ESI report problems paying medical bills.

A report released just yesterday by the Kaiser Family Foundation finds that between 2004 and 2014, average out-of-pocket expenses for workers increased 77 percent, largely due to high deductibles, and people with high deductible plans report problems paying medical bills two times more than those in low deductible plans.

Thanks to the ACA, there are some financial protections for these families with high costs, but they are still significant burdens. The bottom line is that employers and employees are struggling under high health care costs, and tackling affordability requires a multi-stakeholder effort, and employers have a particularly important role to play.

Many employers, both on their own and in concert with other local purchasers, are engaged in innovative efforts to push back against high and rising health care prices, while not sacrificing the quality of care provided to their employees.

The ACA has spurred activity in payment and delivery system reform across public and private sectors, building momentum to improve health care value. For example, a multi-payer initiative in Arkansas is leveraging partnerships with Medicare, Medicaid, state employees, and Walmart to expand primary care medical homes.

Many of new models sparked by the ACA provide opportunities for employers to partner with major government purchasers to pressure providers to reduce inefficiencies and improve quality.

For many employers, workplace wellness programs are intuitively appealing, and these programs, if well designed, commu-

nicated and executed, can make a big difference. Most of us spend most of our waking hours at work, and there is much that employers can do to support a working environment that supports health.

However, some of these programs tie an employee's achievement of a particular health outcome to their health insurance premiums or cost-sharing, but there is very little evidence that doing so actually improves health, increases productivity, or lowers costs.

What they do instead, unfortunately, is raise the barriers for many individuals to access the support they need to achieve better health outcomes.

There is also disturbing evidence that some wellness programs place employees' privacy at risk. Wellness vendors can and do harvest vast amounts of personal health information, but there is no Federal law that restricts what these companies share with business partners for marketing purposes. Yet, many employees face tremendous pressure to participate in these programs, especially when up to 30 percent of the cost of a family premium is at stake.

Just as with workplace wellness programs, some benefit and network changes sound promising on the surface, but may ultimately be more about cost shifting than actually improving health outcomes.

For example, network tiering has been touted as a way to encourage consumers to seek care from higher quality, lower cost providers, but there is limited evidence to suggest that providers in the lowest cost tiers are selected with quality taken into account. Their "preferred" status is sometimes just a function of price.

A fundamental challenge for employers and their workers today is the cost of health care, but many proposed reforms do not get at the primary cost drivers - providers, many of whom use local market clout to demand reimbursement that is disproportionate to the actual value they deliver. With increasing consolidation among provider systems, this problem may only get worse.

Ultimately, it is going to fall to employers in partnership with other purchasers to drive reforms that will ultimately reduce costs and achieve better health care outcomes.

Thank you so much for the opportunity to participate today.

[The statement of Ms. Corlette follows:]

U.S. House of Representatives Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor and Pensions
Hearing: "Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce"
April 14, 2016

Statement of Sabrina Corlette, J.D.
Research Professor and Project Director
Center on Health Insurance Reforms
McCourt School of Public Policy
Georgetown University

Chairman Roe, Ranking Member Polis, and members of this subcommittee: Thank you for the opportunity to participate in today's hearing about initiatives to support and sustain a healthy workforce. My name is Sabrina Corlette. I am a research professor at Georgetown University's Center on Health Insurance Reforms. However, the views I share here today are my own and do not represent those of the university, its faculty or staff.

Most Americans under 65 receive their health coverage through their employer – over 150 million people. Employment-based health insurance, or "ESI" has been the foundation of our health care system for several generations. Among workers, it consistently rates as one of the most popular benefits, second only to paid leave.

In my testimony today I would like to make 2 primary points: (1) The foundation of ESI remains strong, but affordability continues to be a challenge for employers and employees alike; and (2) To improve affordability, an all-stakeholder effort that includes employers is needed to actively engage in local delivery system and payment reforms.

Our system of employer-sponsored insurance remains strong, but affordability is a challenge

In spite of early fears, the Affordable Care Act (ACA) has not caused employers to drop coverage for their workers, nor has it resulted in reductions in employment. On the contrary, the employment-to-population ratio in 2015 was higher than expected.[1] Companies are not shifting full-time workers to part-time status.[2] And coverage trends for ESI have remained stable under the ACA.[3]

What is clear is that employers are benefiting from the significant slowdown in the growth of health care prices, compared to the pre-ACA growth rate. And there is some evidence that these savings are being passed on to workers, as the growth in workers' premium contributions has slowed, and the average contribution is significantly lower than it would have been if cost growth had continued at pre-ACA levels.[4]

Even with these promising trends, affordability remains a huge challenge for too many families. While the growth in workers' share of premiums has slowed, it is still growing – worker contributions to health plan premiums grew an estimated 83 percent between 2005 and 2015.[5]

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[1] Garret B, Kaestner R, Claims That the ACA Would be a Job Killer are Not Substantiated by Research, February 3, 2016. Available at: http://healthaffairs.org/blog/2016/02/03/claims-that-the-aca-would-be-a-job-killer-are-not-substantiated-by-research/.

[2] Moriya AS, Selden TM, Simon KI, Little Change Seen In Part-Time Employment as a Result of the Affordable Care Act, *Health Affairs*, January 2016, vol. 35, no. 1, 119-123.

[3] Kaiser Family Foundation, 2015 Employer Health Benefits Survey, September 22, 2015. Available at: http://kff.org/health-costs/report/2015-employer-health-benefits-survey/. *See also* Blavin F, Shartzer A, Long SK, Holahan J, Employer-Sponsored Insurance Continues to Remain Stable under the ACA: Findings from June 2013 through March 2015, June 3, 2015. Available at: http://hrms.urban.org/briefs/Employer-Sponsored-Insurance-Continues-to-Remain-Stable-under-the-ACA.html.

[4] Jason Furman, The Economic Benefits of the Affordable Care Act, April 2, 2015. Available at https://www.whitehouse.gov/blog/2015/04/02/economic-benefits-affordable-care-act.

[5] Kaiser Family Foundation, 2015 Survey of Employer-Sponsored Health Benefits.

Many think of ESI as the "gold standard" of coverage, but nearly one quarter of people with ESI report problems paying medical bills.[6] For many, the problem is high and rising deductibles. People in high deductible plans are twice as likely to report problems paying medical expenses as those in low deductible plans. Yet deductibles are steadily increasing. The average deductible for covered workers in 2015 was $1,077, up 67 percent from 2010, and up 255 percent from 2006.[7] We are also seeing a trend away from flat dollar copayments to coinsurance, where enrollees are required to pay a percentage of the cost of the service. Coinsurance not only makes it difficult for consumers to understand what their bottom line out-of-pocket costs will be, but for high cost specialty drugs and hospital stays, charges can run to thousands of dollars. Thanks to the ACA, families with these high medical costs get some financial protection, through an annual cap on out-of-pocket costs. But for many middle-class families these amounts pose a considerable financial burden.

Employers are also reducing their support for dependent coverage. In a recent Kaiser Family Foundation survey, 10 percent of employers report that they have eliminated coverage for spouses and domestic partners, and 49 percent report that they are considering doing so within the next five years.[8]

The bottom line? Employers AND employees are struggling under the burden of high health care costs. Tackling affordability requires an all-stakeholder effort, and employers have a particularly important role to play.

Reducing health care costs while protecting consumers

Cost shifting to workers is not happening by accident. While premium cost increases have moderated since the ACA, they are still rising at a faster clip than the overall rate of economic growth.

In response, many employers, both on their own and in concert with other local purchasers, are engaged in innovative, on-the ground efforts to push back against high and rising health care prices, while not sacrificing the quality of care provided to their employees. Many of these efforts, although in early stages, are showing promise in achieving efficiencies and have demonstrated improvements on key quality metrics.

Using Market Clout to Change the Delivery System

Some of our nation's largest employers are using their market clout to keep costs in check. Intel is a good example. After trying a number of different approaches to curb its rising health care costs, including higher deductibles and workplace wellness programs, the company realized a few years ago that while these efforts helped shift costs to employees, they didn't address the root cause of the

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[6] Hamel L, Norton M, Pollitz K et al, The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey, January 2016. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf.

[7] Kaiser Family Foundation, 2015 Survey of Employer-Sponsored Health Benefits.

[8] Ibid.

problem: the ever-higher prices associated with the care its employees were receiving. So it partnered with a major local health system to see if they could improve quality *and* reduce waste in the system. Over five years, Intel's Healthcare Marketplace Collaborative reduced the costs associated with treating three high cost chronic conditions between 24 and 49 percent. At the same time, it was able to demonstrate high levels of patient satisfaction with their care.[9]

Other large companies, such as American Express, Macy's, and Verizon, have formed alliances to share data on provider costs and health outcomes, and potentially use their combined market clout to "target the supply chain" and get better deals from providers.[10] Smaller employers can achieve similar results through multi-payer efforts that are emerging all over the country, such as the one sponsored by the Maine Health Management Coalition, which works with its employer members to change how care is paid for.[11] By joining forces with other local businesses, unions, and health plans, there is evidence that employers can lead the way to a lower-cost, more efficient, more patient-centered health care system.

ACA-Sparked Initiatives to Shift from Volume to Value

The ACA has spurred activity in payment and delivery system reform across the public and private sectors, building momentum to improve health care value. The ACA created the Center for Medicare and Medicaid Innovation (CMMI) to design, launch, and test new payment models to shift our health care system away from fee-for-service, or volume-based, payment, to value-based payment. For example, a multi-payer initiative in Arkansas is leveraging partnerships with Medicare, Medicaid, state employees and Walmart to expand primary care medical homes and improve care coordination for people with chronic conditions.[12] While the evidence on these new models is still mixed, they provide new opportunities for employers to partner with major government purchasers to pressure providers to reduce inefficiencies and improve quality.

Workplace wellness

For many employers, workplace wellness programs are intuitively appealing. A majority of large employers offer at least some form of wellness program. And that's great. Most of us spend most of our waking hours at work, and there is much that employers are doing to ensure that our working environment supports health. These include laudable efforts to improve nutritional offerings in cafeterias and vending machines, opportunities to participate in lunchtime walking clubs, yoga classes, and stress reduction sessions, and redesigning our office space to encourage employees to get up and move around.

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[9] McDonald, PA, Mecklenburg RS, Martin LA, The Employer-Led Health Care Revolution, *Harvard Business Review*, July-August 2015. Available at: https://hbr.org/2015/07/the-employer-led-health-care-revolution.

[10] Louise Radnofsky, Companies Form New Alliance to Target Health-Care Costs, *Wall Street Journal*, February 4, 2016. Available at: http://www.wsj.com/articles/companies-form-health-insurance-alliance-1454633281.

[11] How Employers Can Improve Value and Quality in Health Care, Robert Wood Johnson Foundation and Aligning Forces for Quality, January 2013. Available at: https://www.pcpcc.org/sites/default/files/resources/rwjf403361.pdf.

[12] Stremikis, K, All Aboard: Engaging Self-Insured Employers in Multi-Payer Reform, Milbank Memorial Fund and Pacific Business Group on Health, 2015. Available at: http://www.pbgh.org/storage/documents/Milbank_-_PBGH_Report_FINAL_2_17_15.pdf.

Fewer employers – an estimated 30 percent - tie an employee's achievement of a particular health outcome to health insurance premiums or cost-sharing. That may be because there is very little evidence that doing so will result in either improved health, increased productivity, or lower health care costs.[13] To the contrary, there is strong evidence that, with many conditions, such as obesity, tobacco use, and high cholesterol, financial incentives do little to change behaviors. What they do instead, unfortunately, is raise the barriers for these individuals to access the health care services and support they need to achieve better health outcomes. A smoker won't be able to access cessation counseling if he can't afford the premiums to maintain health coverage. These programs also hit the hardest the people who can afford it the least, as many of the targeted health conditions have greater prevalence among lower-income populations.

There is also disturbing evidence that some wellness programs place employees' privacy at risk. Workplace wellness vendors can and do harvest vast amounts of personal health information from employees. Some require employees to allow access to medical records and claims data in order to participate, and many also require completion of a health risk assessment (HRA) and/or physical exam. Although federal law restricts the information that wellness vendors can share with employers, nothing restricts what these companies can share with business partners for marketing purposes.[14] Yet many employees feel tremendous pressure to participate in these wellness programs, especially when up to 30 percent of the cost of a family premium is at stake (which could mean $5,263 or more each year).

Benefit Design Changes: Tiering, VBID, and Reference Pricing

Just as with workplace wellness programs, many new payment and delivery system reforms sound promising on the surface, but may ultimately be more about cost-shifting than actually improving health outcomes. For example, many insurers and employers have touted network tiering as a way to encourage consumers to seek care from higher quality, lower-cost providers. However, there is limited evidence to suggest that providers in the lower-cost tiers are actually selected with quality taken into account. Their "preferred" status is often just a function of price. At the same time, there is a large body of evidence telling us that consumers often don't understand how to use their insurance plans. When networks are subdivided into three or four tiers, it can be incredibly difficult for consumers to assess what their bottom line costs might be.

Similarly, another trendy concept – reference pricing – needs to be carefully considered in terms of its impact on consumers. It works only if consumers have easy-to-understand and use information about who the lower-cost providers are, if they are reasonably accessible, and if there is sufficient time for the patient to make an informed decision. Yet referring providers are notoriously reluctant to discuss costs

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[13] RAND, Workplace Wellness Programs Study. Available at: https://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf; *see also* Patel MS, Asch DA, Troxel AB et al, Premium-Based Financial Incentives Did Not Promote Workplace Weight Loss in a 2013-2015 Study, *Health Affairs*, January 2016, vol. 35 no. 1, 71-79.

[14] Pollitz K, Rae M, Workplace Wellness Programs Characteristics and Requirements, Kaiser Family Foundation, January 2016. Available at: http://kff.org/private-insurance/issue-brief/workplace-wellness-programs-characteristics-and-requirements/.

with patients, and very few do. Most don't even know their patients' source of coverage when referring them for a test or service.

Another effort – value-based insurance design – is also great in concept, but difficult to execute. Reducing or eliminating cost-sharing for high value services and drugs helps reduce financial barriers to needed care, but hasn't been shown to reduce costs. Raising cost-sharing for low-value services and drugs *might* reduce costs, but few employers want to be in the business of deciding which drugs and services are low value.

Targeting the real culprit (and it's not consumers)

A fundamental challenge for employers and their workers today is the cost of health care. But many proposed reforms don't get at the primary cost drivers: providers and suppliers, many of whom use local market clout to demand reimbursement disproportionate to the actual value they deliver. With increasing consolidation among provider systems and payers, this problem is only likely to get worse. Ultimately, it may fall to employers – in partnership with other major purchasers, including Medicare and Medicaid – to drive the reforms that will ultimately reduce costs and achieve better health outcomes.

Thank you Mr. Chairman and Members of the Committee for the opportunity to testify today. I look forward to the discussion.

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Chairman ROE. Thank you very much. Ms. Franklin, you are recognized for five minutes.

TESTIMONY OF TRESIA FRANKLIN, DIRECTOR, REWARDS AND EMPLOYEE RELATIONS, HALLMARK CARDS, INC., KANSAS CITY, MO

Ms. FRANKLIN. Thank you, Chairman Roe and Ranking Member Polis. I appreciate very much the opportunity to testify before the Committee today on behalf of the American Benefits Council, of which Hallmark is a member.

Briefly, Hallmark is a family owned $3.5 billion company, and as you have acknowledged, mostly in the greeting card business and other social expression products. We have about 5,000 benefits eligible employees and another 2,000 retirees who are eligible for our programs.

Our culture strongly reflects the family ownership. Our CEO is third generation. The average number of years of service at Hallmark is 18 years. We are very planful and careful as we offer these programs to our employees.

I want to start our conversation today focusing on our wellness programs. Hallmark has a very long, rich history of commitment to employee wellness. Hallmark even has a subsidiary company that helps other companies develop their wellness strategy and communication.

Our founder, J.C. Hall, started healthy onsite food services in 1923. That tradition continues to this day. In 1956, we opened an onsite medical facility which provided employees convenience and extra care for support.

These programs have evolved, and today, the Hallmark Health Rewards Program is a program that rewards Hallmark employees with points to be redeemed for gift cards, health care premium credits, and HSA contributions for participating in activities that encourage doing the right thing, getting a routine physical, attending onsite health seminars, *et cetera*.

I next want to focus a little bit on what I believe has been an innovative approach to our health care strategy. In January 2015, Hallmark joined the Aon private exchange. This was a strategic decision. As Hallmark evaluated its role in health care, we adopted an approach of educating our employees about their choices and how to make decisions to best meet their individual needs.

The complexities of health care, the significant changes, and the ever growing costs of health care benefits, resulted in Hallmark seeking this innovative approach.

We had grown frustrated with increasing deductibles and employee premiums, and sought an approach that leveraged market competition between carriers, simplified programs, and could change the dynamics of health care.

The new approach allows carriers to develop services to compete in a geographic marketplace, standardizes plan design across carriers, and provides our employees with state-of-the-art decision-making tools. We moved from self-funded to a fully insured model as part of this move, which we felt moved risk and accountability to the carriers who are best equipped to manage these complexities.

We are no longer in the middle of increasingly complex decisions regarding formularies, network reimbursements, reference-based pricing, or specific appeals by employees around their coverage. We have left these issues to carriers to structure their best approach and compete for our employees' business.

This model also permits our employees to post public comments about their experiences with the carrier in a true consumer feedback model.

We continue to believe that employers play a critical role in our employees' health care. I want to highlight three specific aspects. First, we provide a significant contribution to their premiums. However, we pay the same funding amount whether an employee chooses the most expensive or the most inexpensive or richest benefit. Employees who choose a gold option pay more, from our standard contribution, employees who choose a less costly bronze plan pay less.

Second, we provide onsite and online education facilities and seminars for our employees, and finally, we provide Aon's ongoing service support to answer employee questions and serve as advocates for employees.

I have described for you the path Hallmark has chosen. We have found that the previous one-size-fits-all approach that put Hallmark in the middle of being a health care delivery expert no longer worked for us. Rather, the private exchange model provides employers with this innovation.

However, and this is very important, it is critical to recognize that our path is not necessarily fit for every employer. While this strategy has been right for Hallmark, other employers may decide that more direct involvement with administration and design of their benefits will result in the innovation they seek.

And finally, I think it is very important to consider the legislative framework that makes possible affordable and meaningful benefits. I know tax issues are not within the jurisdiction of this Committee, but within our written testimony we have highlighted two very important elements.

First, the so-called "Cadillac tax," should be repealed, and we want to commend Congressman Courtney for his leadership in authoring bipartisan legislation to do so, and I want to thank you, Chairman Roe, and those members of the Committee that have cosponsored repeal legislation.

Finally, I want to mention the tax exclusion and how critical that is. I would be happy to address this during questions as well.

Thank you again for this opportunity.

[The statement of Ms. Franklin follows:]

TESTIMONY OF

TRESIA FRANKLIN,
DIRECTOR,
REWARDS AND EMPLOYEE RELATIONS
HALLMARK CARDS

ON BEHALF OF THE

AMERICAN BENEFITS COUNCIL

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND THE WORKFORCE
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

"INNOVATIONS IN HEALTH CARE: EXPLORING FREE-MARKET SOLUTIONS FOR A HEALTHY WORKFORCE"

APRIL 14, 2016

My name is Tresia Franklin, and I am Director, Rewards and Employee Relations, at Hallmark Cards ("Hallmark"). I very much appreciate the opportunity to testify before the Committee today on behalf of the American Benefits Council (the "Council"), on whose Board of Directors I serve.

Hallmark is a $3.8 billion business with greeting cards and other products sold in more than 40,000 retail stores across the U.S. – including top mass retailers and the network of Hallmark Gold Crown stores. Our brand also reaches people online at Hallmark.com and through our retail partners' web sites, and on television through cable's top-rated Hallmark Channels and Hallmark Hall of Fame movies. Worldwide, Hallmark offers products in more than 30 languages available in 100 countries. Hallmark has approximately 5,000 benefits-eligible employees and also offers retiree health care benefits to approximately 2,000 individuals.

The Council is a public policy organization representing principally large, multinational 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.

Hallmark and the Council share the perspective that employers have historically played – and continue to play – a critical role in the delivery of important health care benefits to millions of American workers. The manner in which employers have assumed this important role has certainly evolved over time and, as I will describe through today's discussion of Hallmark as one case example, continues to evolve.

My testimony will first focus on the crucial legal framework that has encouraged and enabled the significant and beneficial involvement of employers in sponsoring employee health benefits. Second, I will discuss some of the more innovative and significant developments taking place today with respect to employer-provided health benefits. Using my company as a case study, I will conclude with a discussion of how Hallmark has reshaped its own health benefits to ensure that we are providing the most valuable benefits to our employee population, within the context of globalization and increasing business and cost pressures.

The Current Legal Framework Fosters Innovation in Employer-Sponsored Health Care

The Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code together create the foundation for employers to provide valuable, innovative health benefits to their employees in ways that often cannot be replicated without that strong employer engagement. Private sector employers provide health benefits to 157 million Americans. It is essential that policymakers continue to recognize the unique value of employer-sponsored plans, which significantly reduce burdens and costs on public programs and on individuals, in helping to ensure personal well-being for millions of Americans.

ERISA Preemption. Innovation in employer-sponsored health care thrives in an environment of regulatory certainty. This is, in large part, due to Congress' wisdom 40+ years ago when it included, as part of the enactment of ERISA, a provision that ensures that ERISA plans are free from most state and local regulation. As one congressman noted in statements made prior to

ERISA's enactment, "[w]ith the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29197 (1974) (Statement of Congressman Dent).

Although ERISA preemption preserves some application of state law with regard to employee benefit plans (in areas traditionally covered by state law, such as insurance, banking, securities, etc.), the preemption is very broad. It preempts any state law (which under ERISA includes "all laws, decisions, rules, regulations or other State action having the effect of law," including actions of state agencies or political subdivisions) that "relates to" an ERISA-covered employee benefit plan. The Supreme Court stated that a state law "relates to" an ERISA-covered employee benefit plan if it has some connection to ERISA plans. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

The question of how far ERISA preemption extends has been extensively litigated over the years, but the general purpose of ERISA preemption – to "eliminat[e] the threat of conflicting and inconsistent State and local regulation" – has largely been fulfilled, and it has provided employers with much-needed certainty as to the regulatory landscape applicable to their self-funded health care plans. Without ERISA preemption, employers would have to comply with a patchwork of varying state laws and monitor and adapt to constant state-level changes. Such an environment would make merely staying compliant with the potential myriad state and local laws (many of which could be in conflict with one another) a complex and costly task for employers. Additionally, such an environment would be inhospitable to employer innovation in the design and delivery of health benefits, because of the potential that the resulting innovation could run afoul of otherwise applicable state and local laws.

Tax Exclusion for Employer-Sponsored Health Coverage.

Long standing tax rules that protect employees from tax on health coverage are a major reason employer-provided health insurance is so prevalent. The Internal Revenue Code provides a broad exclusion from gross income (for both federal income and payroll tax purposes) for employer-provided health benefits, including insurance premiums and other employer contributions to provide coverage, as well as the payment or reimbursement of medical expenses not covered by insurance and contributions to certain health-related accounts. *See* Internal Revenue Code sections 105(b) and 106. The exclusion applies with respect to health benefits provided to a current or former employee (including a retiree) and an employee's family members. In general, employee contributions toward premiums are treated as provided by the employer for purposes of the exclusion if contributed by the employee via salary reduction through an employer-sponsored Internal Revenue Code section 125 cafeteria plan.

The existing broad exclusion for employer-provided health care is crucial to employers' abilities to continue to provide dynamic health care solutions to their employees. The exclusion allows employers to mitigate the cost of providing benefits, with net gains to both the employee (in the form of the federal income and payroll tax exclusions) and the employer (in the form of the federal payroll tax exclusion and a healthier workforce).

The exclusion, combined with the need to continually develop and offer forward thinking plan designs and delivery mechanisms as part of a competitive benefits package, encourages employers to carefully identify and implement benefit strategies that are best-suited to their unique workforce and that align with rules governing employer-sponsored plans. This, in turn, motivates service providers and vendors to develop new state-of-the-art products and tools for employers to implement with respect to their workforce.

Although the tax expenditure for employer-sponsored health coverage is often viewed as regressive because the "tax benefit" appears to favor higher-income individuals, in fact, the expenditure is very progressive because the value of the "health benefit" it provides is more significant for lower-income individuals – for whom it would be a greater financial burden to purchase coverage absent an employer-sponsored plan. Middle income Americans derive a much larger share of the benefits from the health plan exclusion than higher income individuals.

The Council also strongly urges Congress to continue the bipartisan effort to repeal the 40% tax on high cost plans (the so-called Cadillac tax). If Hallmark's plan triggered the Cadillac tax, it could seriously complicate our highly successful benefits and wellness initiatives.

For millions of Americans, employer-sponsored benefit programs are vitally important for assuring personal health and financial well-being. If employer-sponsored health benefits are to remain available to Americans, they must continue to be supported by stable tax policy that takes a long-term view.

Current Innovations in Employer-Sponsored Health Care

The ability to innovate and make changes necessary to tailor benefits to a workforce's present need is crucial to balancing an interest in providing vibrant health care coverage to employees and their spouses and beneficiaries with the need to manage the continued growth in health care costs.

Although recent predictions of health care cost increases envisage the lowest such increase (at 4%) in 15 years, this is still more than twice the projected change in the Consumer Price Index. This demonstrates the demands placed on employers in managing such volatile cost growth. And, according to the Willis Towers Watson 2016 Emerging Trends in Health Care Survey, nearly four in five employers (78%) are planning changes to their health plan designs and strategies with the goal of managing health care cost and improving value.

Some of the strategies that are currently being utilized or considered by employers include:

- *Onsite/Near-Site Health Centers*: Providing access on or near the work site to medical care allows employees quick access to care not only for work-related injuries, but also for a variety of minor ailments or injuries. Such quick and easy access to care cuts down on employee "down time" due to medical issues while allowing employers to provide cost-effective care outside of the traditional confines of the group health plan.

- *Wellness and Disease Management Programs*: Because certain conditions, such as diabetes and obesity, drive significant health care costs, helping employees manage and, improve such conditions yields positive results for employees in improving their health and quality of life while also driving down health care costs. Employer plan sponsors are using a variety of methods to help employees achieve such results, including employer-sponsored wellness and disease management programs.

- *Telemedicine*: Electronic access to physicians or other providers – including via phone and online videoconferencing – has become increasingly popular, (Willis Towers Watson predicts the number of employers offering telemedicine visits to increase from 67% today to 90% by 2018). Telemedicine is another "win-win," offering cost-effective and convenient physician services to employees.

- *Centers of Excellence*: While about 31% of employers are using centers of excellence (i.e., medical providers that specialize in particular clinical services) today, that figure is expected to grow dramatically, and could be as high as 73% in 2018, according to Willis Towers Watson.

- *High-Performance Provider Networks*: Similarly, while about 13% of employers are currently utilizing high-performance provider networks (i.e., networks of providers that partner with employers and health plans to offer lower premiums and better value, all offered alongside broad networks), that figure is also expected to rise quickly, to as high as 56% in 2018.

- *Improving Employee Engagement via Technology*: Decision support tools and other engagement technologies are increasingly popular. For example, according to Willis Towers Watson, 52% of employers use technology to enable employees to make better plan selections, and that number could grow to 89% in 2018.

- *Use of Private Exchanges*: An area of considerable growth in the health care arena has been the use of private exchanges, whereby employees are given the ability to direct the purchase of health care coverage from among a group of insurers selected by the employer and using a defined amount of employer funds. Although such private exchanges can take many forms, they have generated significant interest and, increasingly, engagement from employers.

Hallmark's Approach

As mentioned, employers today may choose from any number of combinations of health plan tools. The strength of the system is that an employer can evaluate what works best from a business perspective and align its benefit offerings with its needs, as well as the needs of its particular workforce.

In many instances, employers have been at the forefront of innovation in benefit plan design and delivery. This has been made possible in large part by the important and helpful regulatory regime that I mentioned previously – including ERISA's preemption provision. Employers'

desire for, and actual innovation in, the offering of health and welfare benefits to their employees has increased even more so over the past few years, particularly in light of the increasing costs, complexities, and changes that have been taking place across the health landscape.

Hallmark is no different; we have continuously worked hard to offer a suite of benefit options to our employees and retirees that provides them with valuable benefits while allowing the company to better control costs in this very competitive global marketplace in which we find ourselves. These benefits include offering health coverage through a private exchange as well as incentivizing employees to participate in numerous wellness activities.

Participation in the Aon Private Exchange. Prior to the 2015 plan year, Hallmark sponsored a self-funded major medical plan for our employees. While we were able to offer important health benefits to our employees with this plan, we became frustrated with the ever-growing cost of health coverage as well as the increasing complexities developing across the health landscape. The constantly increasing cost of coverage not only had an impact on Hallmark's bottom line; it also necessitated that we ask our employees to bear some of these growing costs in the form of higher deductibles and premiums. This led us to engage in a strategic evaluation of the benefits we were offering at that time as compared to other, emerging ways to offer health care to employees.

Effective for the start of the 2015 plan year, we moved our health coverage to the Aon private exchange platform. Hallmark employees can now shop on this private exchange with employer-provided premium dollars and choose among a collection of high-value fully insured major medical plans and carriers. Through this partnership with the private exchange, our employees have access to educational tools and decision support in the selection of the health insurance coverage that best meets their individual needs. Our move to the private exchange was premised on its goal of leveraging market competition (among carriers), simplifying and standardizing benefit design, and the possibility of changing the dynamics of health care benefits.

Hallmark – and our employees – have been very pleased with our move to the exchange. It has provided increased choice for employees, simplified plan design across carriers and provided our employees with state-of-the-art decision making tools. Although many major employers understandably want to continue to sponsor a self-insured health plan, from our company's perspective, the move from self-funded to fully-insured coverage has transferred the risks previously borne by Hallmark to the carriers, which has worked well for us in terms of controlling our health care spend. Moreover, carriers now handle the exceedingly complex decisions regarding, among other things, formularies, network reimbursement strategies, reference-based pricing, and employee appeals for specific coverages. In handling these decisions, carriers must keep in mind the need to compete for our employees' business. Overall, there is a significant incentive for carriers to compete with one another to get our employees' business – by developing efficient, effective, and customer-friendly products and processes.

Hallmark has always prided itself on offering valuable health benefits to its employees. One thing that we appreciate about the private exchange is that Hallmark still plays a critical role in our employees' health care as the plan sponsor of the Aon-exchange insurance group health plans, despite having moved much of the complexity to carriers. In particular:

- We continue to provide a significant pre-tax premium contribution to employees to pay for premiums on the private exchange. The amount of Hallmark's contribution is the same regardless of whether the employee chooses the most expensive or the least expensive benefit. Employees who choose a more expensive "gold" option pay more premiums out of pocket than those who choose a less expensive "bronze" option – but in either event, employees receive a base premium subsidy from Hallmark regardless of the coverage option that they choose. This allows for increased choice and efficiency in health care coverage. Moreover, because Hallmark offers an Internal Revenue Code section 125 cafeteria plan in connection with the health insurance coverage options, employees' share of premiums are also paid on a pre-tax basis.

- We provide onsite and online education meetings to facilitate the employee's decision making, and we provide Aon's ongoing service support to answer employee questions and serve as advocates for our employees.

- We regularly evaluate the group health insurance plans offered on the exchange to help ensure they remain the best approach for our employees.

Wellness Initiatives. In addition to offering health coverage through the private exchange, Hallmark engages in other health and welfare initiatives as well. In particular, we have a long, rich history of commitment to employee wellness. Our founder, J.C. Hall, began providing a healthy on-site food service in 1923, and that tradition continues today. In 1956, Hallmark opened an onsite medical facility for employees' convenience and to provide extra support for medical care. In addition, since the 1980s, we have sponsored an integrated approach to employee wellness.

Our wellness initiatives have evolved over the years to reflect innovation in the wellness market as well as our current needs. Today, Hallmark Health Rewards is a program that rewards Hallmark employees with points that can be redeemed for gift cards, health care premium credits or contributions to a health savings account for participation in activities that encourage healthy behaviors such as getting a routine physical or attending an on-site health education seminar. In addition, we sponsor an annual Hallmark Health Fair, which hosts a variety of health vendors and services on site, including on-site health screening for our employees. Hallmark also has a subsidiary that helps other companies develop and communicate their own wellness strategies.

Conclusion

In summary, Hallmark found the previous one-size-fits-all approach that required Hallmark to be a health care delivery expert no longer worked for us. The beauty of the employer-based system lies in the ability of employers to select and use the approach that works best for them given their unique business needs and particular workforces. While the private exchange platform has worked well for Hallmark, we realize that it may not be the right choice for every employer. Accordingly, it is imperative that public policy allow employers to retain significant flexibility to innovate with regard to health benefits, including offering benefits on a self-funded basis or utilizing tools such as telemedicine or high performance provider networks.

At the end of the day, employers such as Hallmark would not be able to offer employees the benefits best suited to them without the flexibility afforded by the statutory and regulatory framework in place under both ERISA (with respect to preemption) and the Internal Revenue Code (with respect to the exclusion for employer-sponsored health coverage).

Thank you very much for the opportunity to testify today. I look forward to answering your questions.

Chairman ROE. Thank you, all. You have been an amazing panel. Everybody came in under five minutes. I hope the members will be as good as you are.

I would like to take this opportunity to recognize Chairman Walberg.

Mr. WALBERG. Thank you, Mr. Chairman, and the heat is on, right, to perform. I thank each of the panelists as well.

Ms. Franklin, appreciate your testimony. It is a Hallmark testimony.

Ms. FRANKLIN. Thank you, sir, appreciate it.

Mr. WALBERG. We know that employer-based wellness programs generally have two thrusts, one at least most of the employers that I meet in my district truly care about their employees. You might find an occasional one that is more materialistic. For the most part, they really care about them and what to see them be successful, healthy, and continue to work.

On the other side, there are certain cost savings to have coverage for employees that are healthy as opposed to ones that have repairable or preventable health issues. We understand at least when you look at it in common sense, why would not an employer want to encourage healthy employees in using wellness programs to do that, but we are also understand more importantly there are employers that are very fearful of what EEOC is looking at, in direct contradiction to what is being pushed in the Affordable Care Act, with the First Lady's nutrition proposals, *et cetera*, and so with the liability concerns that go on there, there are challenges.

I would like, if you would, to speak more fully on the importance of employer-based wellness programs to a healthy workforce, and then secondly, what are some of the hurdles that you encounter as a result of what I believe is EEOC's overreach?

Ms. FRANKLIN. Well, as I said, our programs are part of our culture. Today, as I sit here, in fact, it is the Hallmark Health Week in Kansas City, and employees are having the opportunity to do onsite biometrics screening and other screenings.

It is an element where, I think, does send a message, that this is part of our culture that we care about our employees. You know, I often get asked, well, are you saving money as a result. I have taken a different approach with that. Of course, when my boss asks me that, I say yes, but I will say what we have focused on is a program that really allows our employees who do the right thing to reduce their health care costs through these rewards.

So, when you get a physical and you get a paycheck credit for doing that, it creates the incentive that we think is good behavior for employees to do that.

You are right, Congressman. The myriad of legislation does create a minefield for us to work through, whether it is EEOC, whether it is GINA, whether it is other elements of this that has created that.

In the end, I think our programs do send a message that we care, and it does send a message that if you do the things that make sense for your health, you will pay less for your health care by these rewards.

Mr. WALBERG. It does work, does it not?

Ms. FRANKLIN. I believe so.

Mr. WALBERG. Thank you. Ms. McDonough, as you well know, the EEOC has recently become very engaged in employer sponsored wellness programs, and will soon issue new regulations as it relates to the ADA and GINA.

How has the EEOC's involvement chilled wellness programs affected you specifically?

Ms. MCDONOUGH. Thank you for the question. Employers, who you suggested this in your introduction, employers come to us for a variety of reasons, a lot of them come to get more participation, more engagement with their programs, some are looking at health care savings, some are looking at productivity, so they have a variety of reasons of they are coming to work with Fitbit.

They are looking to bring something effective and engaging and that has longevity into their workplace. In terms of how we see the EEOC guidelines affect that, I think our goal and the goal of all of our employers is to make programs voluntary, to make them effective, to make them fun, but I think there is, and as I stated in my testimony, some further clarity that could allow them the ability to run more effective and engaging programs.

I think clarifying those guidelines so they have a very strong understanding of what is within the guidelines would be very helpful for employers in developing greater wellness programs or launching them to a greater population.

Mr. WALBERG. Also, for the employee, it certainly makes it feel more voluntary if they understand the benefits to them.

Ms. MCDONOUGH. Absolutely. Communication and transparency up front is what leads to great participation rates. So, a shared commitment to health, a culture of health or wellness, and really understanding that the employer and employee what data is being shared, how it is being used, and how that is going to impact the culture within the organization.

Mr. WALBERG. Thank you, I yield back.

Chairman ROE. I thank the gentleman for yielding. Mr. Polis, you are recognized for five minutes.

Mr. POLIS. Thank you. Real interesting testimony. I wanted to address to Ms. McDonough and Ms. Franklin, obviously very exciting ways to encourage wellness and health at the employer level.

What mechanisms have you seen for incentivizing employees to participate and for some of the savings to accrue to the benefit of the employee as well as the employer? I will go to Ms. McDonough first, and then Ms. Franklin.

Ms. MCDONOUGH. Sir, thank you for the question. So, in terms of mechanisms for and incentives that we have seen, it really does vary from employer to employer based on the sophistication of their program. In our six years of history, we have had the opportunity to work with thousands of small- and medium-sized businesses as well as Fortune 500 companies.

The way they incentivize may be very different based on the sophistication of their program. In general, I think they try to align their incentives with the goals of the program. That is where I think Fitbit can actually be very effective.

For example, if you want someone to take a health screening or to get more active, running a collaborative or competitive program that ties into social responsibility and other things that are part of

the culture of the organization actually has everyone's incentives aligned that good health. So that's a very common model.

Mr. POLIS. In your case, they also get a free Fitbit, right?

Ms. MCDONOUGH. There is a variety of models in which that works. So, oftentimes, it is a cost-shared commitment between the employer and the employee.

Mr. POLIS. What is the typical cost of a Fitbit device?

Ms. MCDONOUGH. They range between $60 and $250, based on the features set and . . .

Mr. POLIS. So, the employee benefit might be half the cost of a Fitbit, so it might be $50 or $100, something like that, towards the cost of it?

Ms. MCDONOUGH. That is correct, or even less—

Mr. POLIS. Or the whole cost?

Ms. MCDONOUGH. Exactly.

Mr. POLIS. In any case that is great, Ms. Franklin?

Ms. FRANKLIN. Thank you, Congressman. I want to emphasize our program is voluntary, and so the way we encourage, the dollars, the rewards themselves, are the biggest incentive. Our employees can earn up to $400 in a year doing the various activities.

As I said, we try to make it fun. We do challenges, whether it is a thousand or a Walk to the Moon, we did a Walk to the Moon once, and people accumulated steps as part of that. We did Lose a Ton, people came together in teams. That was one of the more exciting ones because I think the prize was a trip somewhere.

It encourages people to have fun, to create networking opportunities within the company.

Mr. POLIS. Hopefully, where this will go, and maybe someone will comment on this, you know is tying the data on the actual savings back to what the incentive is and how that can earned along with savings to the company. Does anybody want to address that frontier of how we can tie data back to provide the right incentive for employees and save money for employers? Mr. Zern?

Mr. ZERN. I am happy to, thank you. So, there is no doubt data analytics is becoming more prevalent in the health care environment, and how do we tie it back to the return on investment.

I think employers are certainly looking at health benefits differently today. They are looking at it more as an investment in their population and driving a healthier population as maybe in the past where sometimes it was viewed more as an expense.

The engagement of the senior leaders of employers of all shapes and sizes, they are asking those questions. They want to tie data back, and they want to understand their population across the healthiest parts of the population and those equally that need assistance in getting healthier, so it is across the board.

Mr. POLIS. In a follow-up question, if there is a second round we will go more into this, and I think there might be depending on how many questions from the panel there are, but how do we weed out wellness programs that do not increase wellness?

And by the way Mr. Zern, there seems like there would be a lot of those, because there are hundreds or thousands of folks with various wellness programs, I do not know, maybe half of them do, half of them do not, or 90 percent do not and 10 do, whatever it is.

How do we actually make sure that—by the way, the ones that do not enhance wellness may very well have other benefits like employee morale, retention, or other things, but not health care costs and wellness.

How do we weed out—not weed out. I guess how do we differentiate between what a wellness program is or what is a straight employee morale retention program?

Mr. ZERN. There is no doubt the marketplace is a little crowded. But most importantly, employers are looking at how do they continue to communicate effectively what their goals are with their benefit programs.

It could take on a variety of forms, healthy lifestyle, better eating. There are a variety of them. The challenge, I think, that employers face is how do they understand which ones align with their corporate goals most effectively, and then how do they communicate them. That is the big thing.

Mr. POLIS. Thank you. I yield back the balance of my time.

Chairman ROE. I thank the gentleman for yielding. Mr. Guthrie, you are recognized.

Mr. GUTHRIE. Thank you, Mr. Chairman. My first question will be for Ms. McDonough. On Fitbit, employer benefits are becoming more valuable to employees, and you described—I was going to ask you specifically of a case, but you described a case earlier of someone who said saved $280,000, I think you said, because of Fitbit and the data.

I guess my question is are the insurance companies—you have it for a year, you provide the data and they expect to have lower health cost coverage because people are exercising or taking care of their health more, or is it over a longer period of time, you have to actually show the experience?

The one year they start the program, the next year, people go to the hospital less, therefore, they know it is going to be cheaper, or are they accepting the data and having an expectation of better performance?

Ms. MCDONOUGH. Sure. Thank you for the question. Again, employers come to us for a variety of reasons. So they will come to us for return on investment in terms of health care savings and costs. We did have the example of Appirio. I am not sure if you are familiar with them. They are a small business, 700 employees or so, very distributed population.

They needed something virtual to bring their program together.

We work with a lot of companies of that size.

There is also a "value on investment" termed VOI, which includes the productivity and absenteeism and those kinds of things.

Employers are actually looking really holistically across that. There is not an expectation at this point for most employers that there is going to be a direct health care savings cost in the next year.

What is great is that the data will be able to show those outcomes over a period of time.

Mr. GUTHRIE. How long did it take to get that $280,000 in savings? Was that over a couple of years, five years?

Ms. MCDONOUGH. That was actually over just one year, so they did a one year program in 2014, and then affected their premiums in the following year.

Mr. GUTHRIE. That is fantastic. Yeah you're right in the other values there. What kind of roadblocks if an employer wants a Fitbit or a program such as this? What kind of roadblocks are they facing? Do they get discouraged? Or is it ... Or are they always happy?

I know what they are trying to get to, but are there some problems to get to that point that you have seen?

Ms. MCDONOUGH. Specifically, do you mean for the employee or the employer?

Mr. GUTHRIE. For the employer bringing in a program, what kind of roadblocks they may have and they say this is not worth it, or is it worth it. What do they have to fight through?

Ms. MCDONOUGH. Sure. I think this is now the minority, which I think is a great thing, but often times, they do need to sell the program up to an executive suite, so there is a financial commitment, and it has to be a culture commitment to healthy employees and really wanting to make their employees successful.

So that's when ... I also think that the adoption rate, so the 24 percent average participation, can sometimes be a barrier, but again that is what is great about bringing consumer technology into this, you're being able to capitalize on a movement literally that is already happening in the marketplace, and being able to bring that and increase those participation rates.

I think that by bringing those technologies into the corporate marketplace, we are able to push back a lot of those objections.

Mr. GUTHRIE. Thank you very much. Mr. Zern, during an open enrollment period, have you seen employees change coverage from year to year? Do they shop around year to year? What kind of drives them? Is it the network choice, the cost, or they had a pleasant experience with a carrier or an unpleasant experience with a carrier and wanted to just change insurance companies because they did not want to deal?

Mr. ZERN. Thank you for the question. It is all of the above. In our active exchange, I think that is one of the liberating things for the consumer, for the employee. What the employer community really likes is that it gives a tremendous amount of choice to the employee supported by very strong decision support tools.

Left to their own devices, it can be overwhelming, but with great decision support tools, you get employees that are—they normally start with what is the right level of coverage for their situation, whether they are an individual or a family situation. Then they will go into looking at networks, their experience with insurance companies.

Our survey results show that price is really kind of the last determinant of their selection. It is plan design, then network, experience with the insurer, and then its cost.

Mr. GUTHRIE. Thanks. I am in the manufacturing business or I was, and in human resources involved in here is the health insurance plan, and people just took it and you moved forward.

I understand you have to allow your employees to rate the carrier. Has that changed the insurance companies' behavior by actually having ratings from their customers?

Mr. ZERN. It is one of our newer parts of our innovation of our active exchange. Consumer ratings are certainly piquing the attention not only of our insurance companies that are part of our exchange, but also their employers. I think that is also factoring into how they view their partners on the exchange.

It really kind of cuts across all the key stakeholders, from the employer, provider, and the insurer.

Mr. GUTHRIE. It is really bringing the customer into the mix.

Mr. ZERN. Exactly.

Mr. GUTHRIE. That is innovative and appreciated. I have run out of time, so I yield back.

Chairman ROE. I thank the gentleman for yielding. Ranking Member Scott, you are recognized.

Mr. SCOTT. Thank you, Mr. Chairman. I think it is important to remind people where we were when we passed the Affordable Care Act. We were experiencing cost increase routinely in double digits for thousands of people; at one point 14,000 people a month were losing their insurance. Those with preexisting conditions, if they could get insurance, they paid exorbitant rates. They usually could not get insurance, and millions others did not have insurance.

The proposal for a government takeover single payer plan could have solved these problems and reduced overall health care budgets significantly, but the government takeover did not pass. We instead passed a more modest market-based approach, patterned after RomneyCare in Massachusetts, a Republican plan, but that has been successful.

The costs have increased since the Affordable Care Act are the lowest in decades, probably half a century. Those with preexisting conditions can get insurance at the average rate. We have the highest portion of people with insurance in recorded history, children up to 26 years old can stay on their parents' policies. Women are no longer paying more for insurance than men. We are closing the doughnut, the prescriptive drug doughnut hole, preventive services, annual check-ups are without co-pays or deductibles.

Since the Affordable Care Act, those that had warned of job loss, are forced to explain the longest continuous number of months of job growth since records have been kept. So that's where we are. That is where we are since the Affordable Care Act.

Ms. Corlette, one thing that has not been completed is the Medicaid expansion. Some states have not expanded Medicaid. Can you comment on the effect that has had on the people who are in the gap for insurance – in the Medicaid gap – that is caused by the failure of some states to expand Medicaid?

Ms. CORLETTE. Certainly, Congressman, and thank you for the question. I think this is something that I hope that Congress will address soon in whatever way it can, and also for the states that have not yet expanded Medicaid, this is a true moral failing.

I believe we have I think an estimated three million people who because their incomes are too low cannot get access to the kind of help with premiums to buy health insurance that people who have incomes above 100 percent of poverty have.

I think that kind of inequity is simply wrong and it is also demonstrated that it is having not just an impact on the families that cannot afford the insurance but actually on many local providers, hospital systems and others that are really suffering because the people that they serve cannot afford the care.

Mr. SCOTT. The failure to expand Medicaid also affects those with insurance because they have to cover the cost shifting. People who are in the gap without insurance get sick, go to the hospital. Can you make a comment on that concept of cost shifting?

Ms. CORLETTE. Sure. That is a problem. I do not know that it has been exactly quantified, but essentially the problem is that just because you do not have insurance does not mean that you do not ever have health problems.

So what happens is that many people because they cannot pay for care, they wait until the last possible minute when the problem has become perhaps even a crisis or much more severe than it otherwise would have been. They must go to the emergency room, and somebody has to pay for that care.

Typically, what the hospital does is shift those costs over to other payers, privately insured, and other payers. We all pay for it in some way, so it is penny wise and pound foolish for these states that have not expanded it and continue to fail to do so.

Mr. SCOTT. Ms. Corlette, can you make a comment on the issue of privacy in the wellness plans, whether or not people are coerced into revealing private information as a result of participation in wellness plans?

Ms. CORLETTE. Sure, absolutely. I should just first of all say that I think workplace wellness programs can be incredibly important and effective. But you have identified one particular area of concern, which is that under current Federal rules and under the proposed EEOC rules, somebody making $50,000 a year could be asked or told that if they do not complete a health risk assessment or if they do not agree to have personal health information turned over to a wellness vendor, as much as $5,000 of health care premiums could be at stake. In other words, they could be asked to pay more in health premiums, as much as $5,000 or more.

It is really hard for me to understand how that would not be considered coercive for somebody making that amount of money. I think they would feel under tremendous financial pressure to complete that health risk assessment and participate. So to me, that is not voluntary, and it does not fall under anybody's common sense definition of what voluntary means.

Mr. SCOTT. Thank you. Mr. Chairman, can I ask unanimous consent to enter two documents for the record, one, a comment to the EEOC regarding the proposed rule on wellness programs and its effect on the *Americans with Disabilities Act*, and another comment to the EEOC regarding the proposed rule related to wellness programs and the *Genetic Information Non-Discrimination Act*?

Chairman ROE. Without objection, so ordered.

[Additional submissions by Mr. Scott follows:]

Congress of the United States
Washington, DC 20515

July 13, 2015

The Honorable Jenny R. Yang
Chair
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, DC 20507

Dear Chair Yang:

We write regarding the Equal Employment Opportunity Commission's (EEOC) proposed rule, *Amendments to Regulations Under the Americans with Disabilities Act*, issued to ensure that wellness programs offered by employers comply with the Americans with Disabilities Act (ADA). As strong supporters of both the Patient Protection and Affordable Care Act (ACA) and our nation's antidiscrimination laws, we are firmly dedicated to ensuring that employer-provided wellness programs are administered in an inclusive and responsible way, and that a worker's personal information is protected. For the past fifty years, the EEOC has ensured that the protections afforded to workers under our nation's antidiscrimination laws exist not only on paper, but also in practice. The EEOC's guidance and regulations—combined with the important legal precedent determined through litigation—help make our nation's workers and workplaces stronger. To continue this important work of upholding the rights of all employees nationwide, we request that the EEOC make minor changes to its proposed regulations, so that no employee's private health information is put at risk.

The ACA allows employers to offer financial incentives or disincentives to encourage participation in wellness programs. Many wellness programs offered to employees include a Health Risk Assessment—a questionnaire that contains a number of health and lifestyle questions used to evaluate the health of an individual employee. While the ADA allows employers to collect this information as part of an employee health program, it clearly states that such programs must be voluntary. We appreciate the EEOC's effort to reconcile the ACA's approval of financial incentives as part of a wellness program with the ADA's protections for those with disabilities. However, we are concerned that the proposed rule could still permit employers to make financial incentives contingent on employees' provision of private health information, in violation of the ADA.

As the cornerstone civil rights law for people with disabilities, the ADA generally prohibits employers from requiring medical examinations or asking employees "disability-related" questions that are not job-related and consistent with business necessity. However, disability-related information may be disclosed voluntarily for the purposes of accommodation, and in other restrictive circumstances. The ADA also provides a limited exception that allows for voluntary medical examinations and inquiries as part of employee wellness programs that are offered to employees. Historically, the EEOC has defined a "voluntary" wellness program that is

permissible under the ADA to be one that does not require participation or penalize employees who do not participate, through financial disincentives or other means.

The EEOC's recent proposed regulation departs from this approach by allowing plans that offer financial incentives (whether they are in the form of a reward or a penalty) of up to 30 percent of the total cost of an employee-only health care plan to still be considered "voluntary." A worker should not feel pressured in any way to provide "disability-related" information to his or her employer as part of a wellness program. We ask that changes be made to the proposed regulation to provide further clarification, preserve the ADA's historical interpretation of "voluntary," and ensure that workers do not feel any level of coercion or pressure to answer "disability-related" questions.

We believe that the EEOC can develop a sound policy that can accommodate financial incentives up to the 30 percent threshold outlined in the ACA, while also complying with the ADA by stipulating that these incentives cannot be contingent upon answering any "disability-related" questions asked through a wellness program. This approach has precedent in the regulations implementing the Genetic Information Nondiscrimination Act (29 C.F.R. § 1635.8 (2010)) which allows for employees participating in a wellness program to skip genetic information questions and still be eligible for the financial incentives associated with the wellness program, making questions about employees' genetic information truly voluntary. We urge the EEOC to consider using a similar approach in making its final regulation.

With regard to the privacy of the employee, we note that the proposed rule makes clear that wellness program adhere to the Health Insurance Portability and Accountability Act (HIPAA) rules "where a wellness program is part of a group health plan." The proposed rule also reaffirms that employers sponsoring wellness programs that obtain "identifiable health information from or on behalf of the group health plan, as permitted by HIPAA" cannot use or disclose the sensitive information in a manner inconsistent with HIPAA. We encourage further protections to ensure that this safeguard remains intact, particularly in light of the fact that employer-provided wellness program—even if administered by a covered entity—may have the unintended effect of exposing non-HIPAA covered entities, such as some employers, to sensitive medical information. The EEOC must vigilantly protect employees' rights to keep their sensitive health information private.

Again, we appreciate the EEOC's willingness to issue further guidance and provide more clarity to employers seeking to implement or continue employer-based wellness programs. We remain steadfast in our belief that wellness programs can co-exist with robust civil rights protections.

We therefore encourage the EEOC to make needed adjustments to its proposed rule in order to guarantee that the equal opportunity and privacy of all employees is respected.

We look forward to continuing to work with you on these issues.

Sincerely,

Robert C. "Bobby" Scott
Ranking Member
House Committee on Education and the Workforce

Elizabeth Warren
U.S. Senator

Steny H. Hoyer
House Democratic Whip

Patty Murray
Ranking Member
Senate Committee on Health, Education, Labor, and Pensions

Frederica S. Wilson
Member of Congress

Robert P. Casey, Jr.
U.S. Senator

Janice D. Schakowsky
Member of Congress

Richard Blumenthal
U.S. Senator

cc: The Honorable Constance A. Barker, Commissioner
The Honorable Chai R. Feldblum, Commissioner
The Honorable Victoria A. Lipnic, Commissioner
The Honorable Charlotte A. Burrows, Commissioner

Congress of the United States

Washington, DC 20510

February 2, 2016

The Honorable Jenny R. Yang
Chair
U.S. Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, DC 20507

Dear Chair Yang:

We write regarding the Equal Employment Opportunity Commission's (EEOC) proposed rule, *Amendments to Regulations Under the Genetic Information Nondiscrimination Act of 2008,* issued to ensure that wellness programs offered by employers comply with the Genetic Information Nondiscrimination Act of 2008 (GINA). As you know, GINA provides important protections against genetic discrimination that generally prohibit employers from requesting, requiring, or purchasing an employee's genetic or family health information in order to protect employee privacy and avoid the use of such data for discriminatory purposes. For the past fifty years, the EEOC has ensured that the protections afforded to workers under our nation's antidiscrimination laws exist not only on paper, but also in practice. The EEOC's guidance and regulations, combined with the important legal work to protect employee rights, help make our nation's workers and workplaces stronger. We also greatly appreciate that the EEOC extended the comment deadline for the proposed rule to allow all stakeholders additional time to weigh in on this important issue. To continue its important work protecting the rights of workers, we ask the EEOC to consider our concerns as the proposed regulation is finalized.

The Affordable Care Act (ACA) allows employers to offer financial incentives to participate in employer-provided wellness programs. As strong supporters of both the ACA and our nation's antidiscrimination laws, we are firmly dedicated to ensuring that these wellness programs are administered in an inclusive and responsible way and that workers' personal information is protected. While we appreciate the EEOC's effort to reconcile the ACA's allowance of financial incentives as part of wellness programs with the worker protections provided under GINA, we are concerned that this proposed rule allows employers to condition large financial incentives on a spouse providing sensitive medical information protected by GINA, meaning that an individual could be under significant financial pressure to provide this information to his or her spouse's employer.

As you know, GINA provides protections for genetic information beyond the individual providing such information. The statutory definition of protected genetic information covers the family medical history of the person providing the information, including information about the current health status of a spouse. For example, if the spouse of an employee participating in a wellness

program provides information about his or her current or past health status, that information is protected genetic information *of the employee* under GINA. Therefore, requesting the medical information of a spouse will specifically invoke GINA, as that information would constitute genetic information, and therefore be protected under GINA, as information of that employee.

The EEOC's 2010 GINA implementation regulations state that "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."[1] Additionally, those regulations make clear that an employer may request—but not require—an employee to provide his or her own genetic information as part of a wellness program. Specifically, those regulations clarify that "a covered entity…may offer financial inducements for completion of health risk assessments…provided the covered entity makes clear, in language reasonably likely to be understood by those completing the health risk assessment, that the inducement will be made available whether or not the participant answers questions regarding genetic information."[2]

The proposed regulation leaves these portions of the 2010 GINA regulations intact for most genetic information protected under GINA, but proposes new rules for when a wellness program asks an employee's spouse about his or her medical information. Much like the proposed rule that the EEOC released in April 2015 pertaining to the interaction between wellness programs and Title I of the Americans with Disabilities Act (ADA),[3] this proposed regulation seeks to redefine the requirement that wellness programs asking for information protected by the ADA or GINA protected information be "voluntary" by allowing a wellness programs to use a large financial inducement to solicit certain protected information. The provisions of the ACA that incentivize employer-provided wellness plans, which can include health risk assessments, should not be used to subvert GINA protections and should not be interpreted in a manner that would change the EEOC's historical definition of voluntary participation.

The proposed regulation would permit employers to condition financial rewards or penalties worth up to 30 percent of the total annual cost of coverage of the health plan – which could mean $5,263 or more per year[4] – on an employee's spouse providing protected health information as a part of a wellness program. This is a departure from current regulations, which hold that no financial inducements can be offered in exchange for genetic information. It also problematically reinforces and goes beyond the EEOC's proposed regulations on wellness programs and the ADA, which would limit the total incentives offered to an employee to 30 percent of the total annual cost of *employee-only* coverage. By allowing incentives up to 30 percent of the more expensive *family* coverage cost, the proposed rule permits employers to condition an even higher amount of money on the participation of a spouse in a wellness program. We have significant concerns that the financial inducements allowed under both the ADA and GINA proposed rules are so substantial that they will have the effect of making the provision of protected information via wellness

[1] Regulations Under the Genetic Information Nondiscrimination Act of 2008, 29 C.F.R. § 1635.8 (2010)
[2] Id.
[3] Amendments to Regulations Under the Americans With Disabilities Act, 80 FR 21659 (proposed April, 20, 2015) (to be codified at 29 C.F.R. pt.1630)
[4] This is based on average annual family premiums in 2015 of $17,545. kff.org/report-section/ehbs-2015-section-one-cost-of-health-insurance/

programs compulsory in practice. A recent New York Times article agreed, calling these financial inducements "...an offer employees simply can no longer refuse."[5]

Although we are pleased that offering a financial inducement for an employee's personal genetic information is still prohibited and that the proposed regulation prohibits incentives for dependents to disclose additional health or genetic information, we encourage the EEOC to reconsider the implications for spouses under the proposed GINA regulation. In addition, as several of us have previously expressed, we continue to be concerned with the implications of the large financial inducements allowed under the earlier proposed ADA regulation to incentivize employees to provide their own personal health information.[6] In both instances, these proposed rules could lead to wellness programs that make the provision of protected information for an employee and his or her spouse coercive, rather than voluntary – which contradicts the intent of both of these important laws.

We encourage the EEOC to make needed changes to the proposed rule in order to guarantee that the equal opportunity and privacy of all employees is respected and we ask that, in developing the final rule, the EEOC address the following concerns:

1. Under both current GINA regulations and past EEOC guidance, a 'voluntary' wellness program has been defined as one that does not require participation or penalize employees who do not participate through financial disincentives or other means. The EEOCs' 2015 regulations on the ADA and GINA allow for financial incentives or penalties of up to 30 percent of the total cost of a health plan. EEOC has changed its definition of 'voluntary' in its 2015 proposed regulations and we ask that the final regulations reflect policy that is consistent with the EEOC's own previous definition of "voluntary."

2. The EEOC's 2010 regulations implementing GINA make clear that employees participating in a wellness program must be able to skip genetic information questions and remain eligible for the financial incentives and protected from any financial penalties associated with the wellness program.[7] The EEOC has departed from this approach in the 2015 proposed regulations and we ask that the final regulation reflect policy that is consistent with the approach used in its previous GINA regulations for all GINA-protected information.

It is our position that wellness programs can and should co-exist with robust civil rights protections. We believe that the EEOC can develop a sound policy that can accommodate financial incentives and protect the privacy of sensitive genetic information. We appreciate the EEOC's willingness to address this issue through thoughtful guidance that provides additional clarity to employers.

We look forward to continuing to work with you on this important issue.

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[5] Abelson, Reed. *Employee Wellness Programs Use Carrots and, Increasingly, Sticks.* The New York Times.
[6] Scott, Robert, Elizabeth Warren, Et al. Letter to Chair Yang, EEOC. 13 July 2015.
[7] Regulations Under the Genetic Information Nondiscrimination Act of 2008, 29 C.F.R. § 1635.8 (2010)

Sincerely,

ROBERT C. "BOBBY" SCOTT
Ranking Member
Committee on Education and the Workforce

ELIZABETH WARREN
U.S. Senator

FREDERICA S. WILSON
Ranking Member
Subcommittee on Workforce Protections

PATTY MURRAY
Ranking Member
Senate Health, Education, Labor and Pensions Committee

LOUISE McINTOSH SLAUGHTER
Member of Congress

RICHARD BLUMENTHAL
U.S. Senator

JANICE D. SCHAKOWSKY
Member of Congress

SHERROD BROWN
U.S. Senator

cc: The Honorable Constance A. Barker, Commissioner
The Honorable Chai R. Feldblum, Commissioner
The Honorable Victoria A. Lipnic, Commissioner
The Honorable Charlotte A. Burrows, Commissioner

Mr. SCOTT. Thank you.

Chairman ROE. Mr. Carter, you are recognized.

Mr. CARTER. Thank you, Mr. Chairman, and thank all of you for being here. This is certainly an important subject that we all need to be paying particular attention to, and I want to thank Chairman Roe for his efforts in bringing this to light before this subcommittee.

I am a small business owner. I am a pharmacist by trade. I own three—excuse me—my wife now owns three independent retail pharmacies with about 19 to 20 employees. We value that relationship very much between with our employees, and some are very long term, been with us for 28 years, and that is certainly very important.

Their health is important. Their health is important to me as an employer, I need them to show up for work. I depend on them. Obviously, I could not do what I am doing here without them being there. This is very important.

However, like all small business owners, I have been faced with the dilemma of trying to reduce health care costs, and that is something that has really been a struggle recently, as you can imagine. I am not any different from any other small business owner in that respect.

Ms. McDonough, I want to speak to you. First of all, I think we are all familiar with Fitbit and what it does and the benefit it can have. As we get to a more socially conscious health care society, if you will, these are the type of things that we are looking at. I am concerned because—not concerned, inquisitive as to the collection methods.

As I understand it, if I were to provide my employees with the Fitbit, if I wanted to get the information, I would have to get their permission to get it first of all?

Ms. MCDONOUGH. Absolutely.

Mr. CARTER. Okay. That data that is relayed to me, how can we make sure that it is going to be private and it's going to be secure? They are going to want to know that and they should. If they do not want to know it, they should want to know it.

Ms. MCDONOUGH. Absolutely. Privacy and security of our user's data and the trust of our customers is paramount at Fitbit. We have a very clear, easy to read privacy policy that we share with all the consumers. It is written in plain English so that they can understand that. That is for all the consumers who use Fitbit products.

When we work with an employer on an employer wellness program, they actually have to opt in and give active explicit consent to share data with their employer. And that is a subset of the actual data that is collected by Fitbit overall.

Some of the devices collect things like heart rate or GPS when you are out running if you are using that functionality. That data is not shared with an employer when they work with Fitbit directly.

The type of data that might be shared would be steps and distance and active minutes. So data that would be beneficial and useful for them to run an effective and engaging program. The employee has the opportunity to—again, the programs are voluntary,

so they do not have to agree to share their data, and they can also opt out at any time.

Mr. CARTER. Okay. One final question for you, as a small business owner, we have asked about the barriers the employers have, but what about small business owners? What kind of barriers do they typically have?

Ms. MCDONOUGH. I am so glad you asked this question because I am really passionate about supporting small businesses, and I actually think it is through the use of technology that small and mid-sized businesses can actually have really effective wellness programs.

There are a number of vendors who will only work with very large employers. We work with and we are ourselves a small business. I am very passionate about it and real excited about it.

The barriers tend to be that it is one person who is responsible for all of H.R. and benefits and staff—

Mr. CARTER. That is usually the owner.

Ms. MCDONOUGH. Exactly. You have been there. What is great about the advent of the technology that we can provide is we make it very easy and streamlined, and we take a lot of pain points for the small business owner and we also solve those for them.

Mr. CARTER. Great. Very quickly, Mr. Zern and Ms. Franklin, I know that private exchanges, they offer a lot more flexibility. I am just wondering—Ms. Franklin, I believe Hallmark has recently changed to a private exchange. I am just wondering about the experience you have had with that.

Ms. FRANKLIN. It has—Thank you, Congressman. It has been a very positive impact to our workforce. It has given employees the opportunity to learn how to determine what health care plans best meet their needs. It is not an one-size-fits-all approach, as I mentioned.

It very much empowers the individual to be part of the process. That has been very, very valuable. It gives our employees choice. They can choose from a variety of national or even local carriers. I think it introduces the opportunity to truly make health care a consumer focused product.

Mr. CARTER. Great. Thank you. Mr. Chairman, I yield back.

Chairman ROE. Hopefully, the H.R. director is doing okay at your business.

Mr. CARTER. You know I got problems with it, but I am dealing with it.

Chairman ROE. Mr. Courtney, you are recognized.

Mr. COURTNEY. Thank you, Mr. Chairman. Thank you to the witnesses for your outstanding testimony today.

Again, just to follow up on Mr. Scott's comments, I come from the State of Connecticut, which is a State that fully embraced the Affordable Care Act. In 2010, our uninsured rate was about 9 percent. Last fall, the latest statistics that came out, it is now 3.8 percent.

The exchange, which again I think has been touted as the highest functioning exchange in the country by Forbes Magazine, the individual policies, private policies, that were sold through the exchange, the actual premium price went down by 5 percent. I am

going to say that again, went down by 5 percent, in terms of what was offered last year.

Again, like many of us, I am a former employer and believe in the employment-based component of the system. Again, what we are seeing in Connecticut is that despite some of the hysteria, that employment-based benefits are alive and well and that some of the really good solid initiatives like wellness programs or private exchanges are totally free to operate, and that is all good.

Like any measure, particularly one that had 440 sections, there are provisions which even those of us who voted for it had concerns with, and as was mentioned by Ms. Franklin, the excise tax, which we pushed against the administration back in 2010 and got delayed til 2018, we again succeeded last year in terms of delaying it to 2020.

H.R. 2050 has 186 co-sponsors, 70 percent of the House Democratic caucus to strike this provision from the law, and there is nothing, I think, contradictory about that. As I said, any law always can use sprucing up and improvements.

The administration actually with their budget that came over this year kind of acknowledged some of the criticisms that we have been weighing against it because they at least tried, I think, vainly, to come up with some actuarial adjustments, which again, I just think at the end of the day is just not really—no one is that smart and no one is that capable in terms of coming up with those kinds of fixes. So, we should strike from it.

But you know—Stepping back and looking at the big picture, one of the things again that was predicted was it was going to be this huge negative impact in terms of America's health care sector.

Last month, the Bureau of Labor Statistics, which came out with again another positive jobs report, 215,000 jobs added to the U.S. economy, 37,000 of those jobs were in the health care sector, 10,000 in hospitals, and about 27,000 in ambulatory care. In the hospital sector in the last 12 months, the employment in that sector has grown by 183,000 jobs in the last year.

Mr. Chairman, I would ask that those figures from BLS be entered into the record.

Chairman ROE. Without objection.

[Additional submission by Mr. Courtney follows:]

Contents

Current Employment Statistics Highlights

March 2016

Release Date: April 1, 2016

Prepared by Staff of the National Estimates Branch
Current Employment Statistics Survey
U.S. Bureau of Labor Statistics

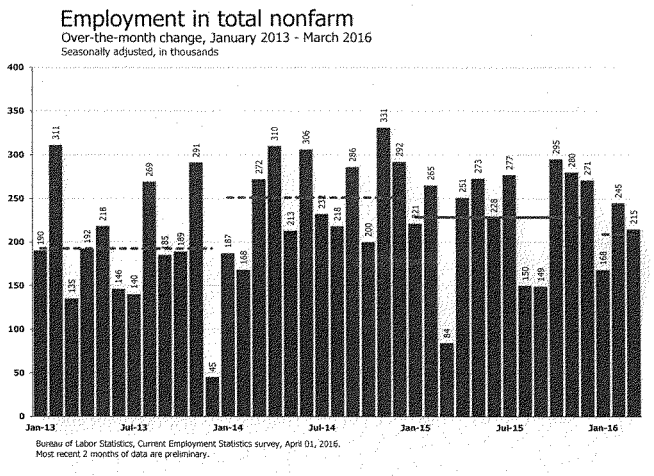
202-691-6555
Email CES

Current Employment Statistics Survey Summary, March 2016

Nonfarm employment rose by 215,000 in March. Retail trade, construction, and health care added jobs, while manufacturing and mining lost jobs.

Average hourly earnings of all private sector employees increased by 7 cents, following a 2-cent decline in February. Hourly earnings have risen by 2.3 percent over the year. Average weekly hours, at 34.4 hours, were unchanged over the month.

The employment change for January revised from +172,000 to +168,000. The change for February revised from +242,000 to +245,000. Over the past 3 months, job growth has averaged 209,000 per month.



+51,000 Education and Health Services

In March, employment rose by 37,000 in health care. Ambulatory health care added 27,000 jobs, and hospitals added 10,000 jobs. Over the year, health care has added 503,000 jobs.

+48,000 Retail Trade

Retail trade added 48,000 jobs in March. General merchandise stores, health and personal care stores, building material and garden supply stores, and auto dealers added jobs. Over the past 12 months, retail trade has added 378,000 jobs.

+37,000 Construction

Construction employment rose by 37,000 over the month. Residential specialty trade and heavy construction added 12,000 and 11,000 jobs, respectively. Over the past 12 months, construction has added 301,000 jobs.

+40,000 Leisure and Hospitality

Employment in leisure and hospitality continued to trend up in March. Over the year, the industry has added 472,000 jobs; food services and drinking places accounted for nearly 80 percent of this gain.

Current Employment Statistics Survey Summary, March 2016

+33,000 Professional and Business Services

Employment changed little in professional and business services during March. Services to buildings and dwellings added 13,000 jobs. Thus far in 2016, employment in professional and business services has changed little , averaging an increase of 20,000 jobs per month, compared to gains averaging 52,000 per month in 2015.

+20,000 Government

Government employment changed little in March. Over the past 12 months, employment in the sector is up by 121,000, with most of the increase coming from local government excluding education (+88,000).

+15,000 Financial Activities

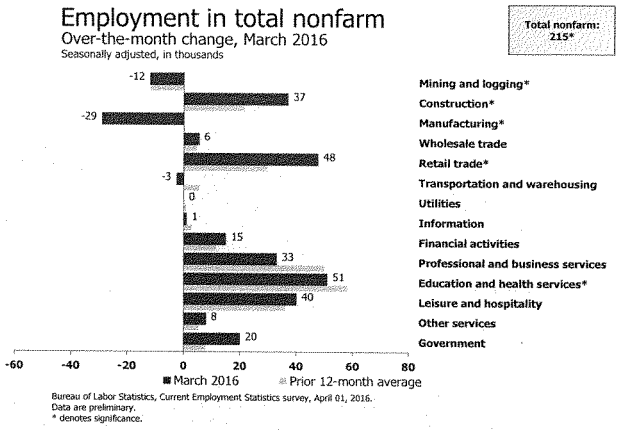
Over the month, employment continued to edge up in financial activities. Credit intermediation and related activities added 9,000 jobs in March, with commercial banking accounting for 5,000 of the increase.

-29,000 Manufacturing

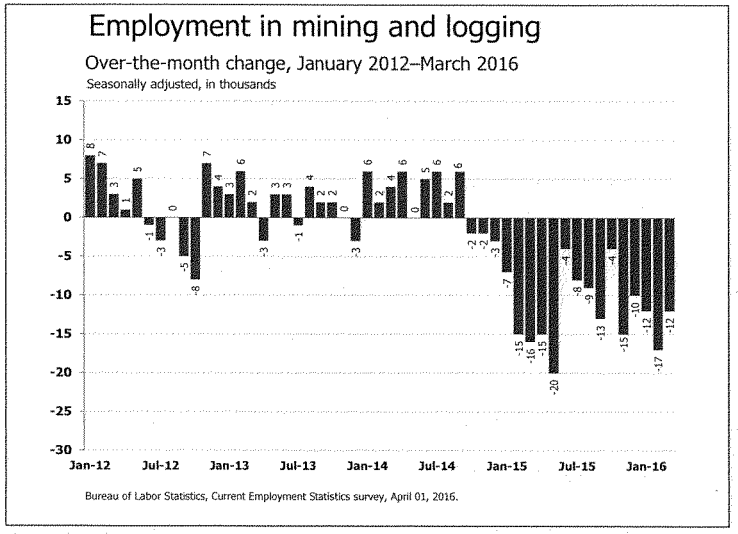
In March, employment decreased by 29,000 in manufacturing. Durable goods industries accounted for 24,000 jobs lost, including declines in machinery, computer and electronic products, and primary metals. Since reaching an employment peak in March 2015, durable goods manufacturers have cut 68,000 jobs.

-12,000 Mining and Logging

Mining continued to lose jobs in March (-12,000). Since last reaching a peak in September 2014, employment in the industry has decreased by 184,000 or 20.4 percent. Support activities for mining accounted for 145,000 of the declines during this period, including a loss of 10,000 jobs in March.



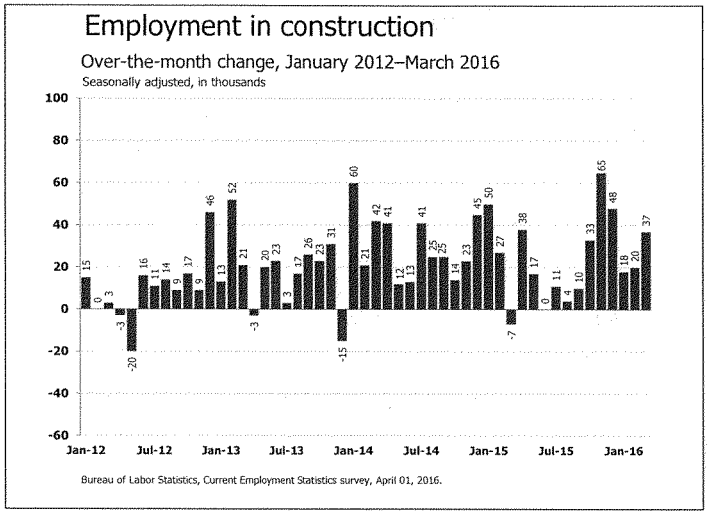
Mining & Logging



Employment in mining and logging declined by 12,000 in March.

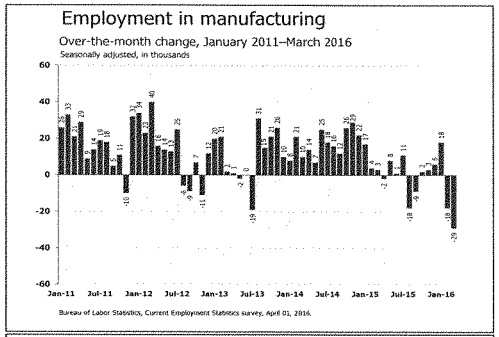
Most of the loss can be attributed to support activates for mining, which lost 10,000 jobs over the month.

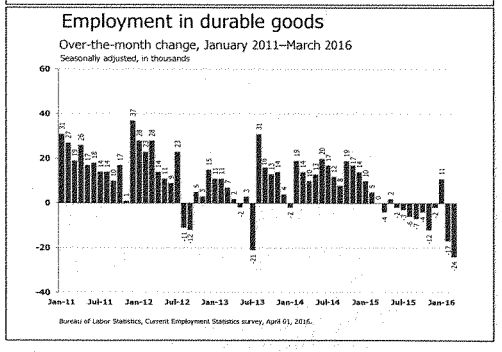
Construction



Construction added 37,000 jobs in March. Heavy and civil engineering construction added 11,000 jobs. Within specialty trade contractors, residential specialty trade contractors continued to add jobs (+12,000).

Manufacturing





Manufacturing lost 29,000 jobs in March. Nearly all of the job losses occurred in durable goods, while nondurable goods employment changed little (-5,000).

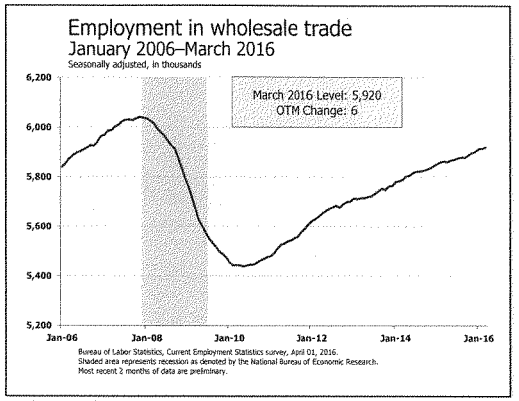
The one-month manufacturing diffusion index declined to 37.3, the lowest since January 2010. The diffusion index measures the dispersion of employment change in manufacturing, with a value below 50 indicating that more manufacturing industries are losing jobs than adding.

Average weekly hours in manufacturing declined 0.1 hour for all employees and was unchanged for production employees. Over the past 12 months, average weekly hours have declined 0.3 hour for all employees and have not changed for production employees (-0.1 hour).

In March, durable goods lost 24,000 jobs, with significant losses in primary metals (-3,000), machinery (-7,000), and semiconductors (-3,000). Durable goods employment reached a recent peak in March 2015 and, since then, has declined by 68,000, led by losses in machinery (-46,000), fabricated metal products (-36,000), and primary metals (-22,000).

Summary | Mining & Logging | Construction | **Manufacturing** | Trade: Wholesale Retail | Transp., Warehousing & Utilities | Information | Financial Activities | Professional & Business Services | Private Education & Health Services | Leisure & Hospitality | Other Services | Government

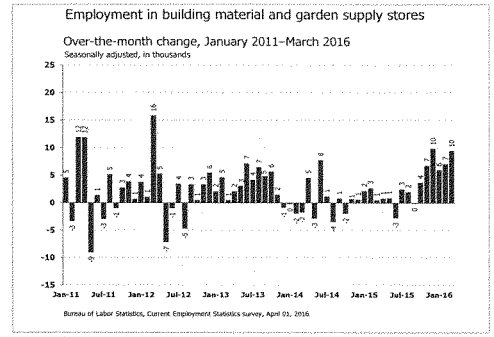
Wholesale Trade



Employment in wholesale trade changed little in March (+6,000). Over the past 12 months, the industry has added 58,000 jobs.

Summary | Mining & Logging | Construction | Manufacturing | **Trade: Wholesale** Retail | Transp., Warehousing & Utilities | Information | Financial Activities | Professional & Business Services | Private Education & Health Services | Leisure & Hospitality | Other Services | Government

Retail Trade



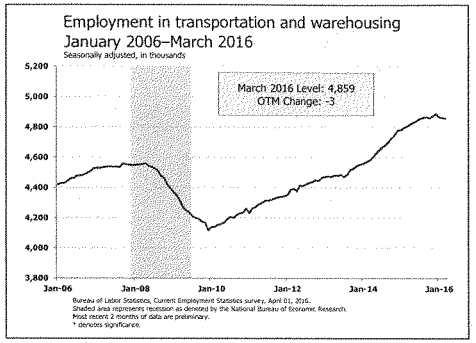
In March, employment in retail trade grew by 48,000, bringing the total growth in 2016 to 181,000. Employment in most of the component industries trended upward, led by growth in general merchandise stores, health and personal care stores, and building materials and garden supplies stores.

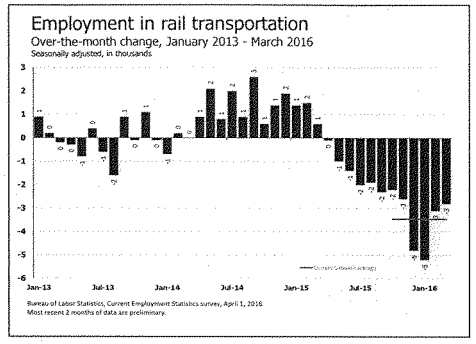
Continuing its upward trend, employment in building materials and garden supplies stores increased by 10,000 in March. During the past 6 months, this industry has added 43,000 jobs.

After essentially no net job growth over the prior 12 months, employment in health and personal care stores grew by 10,000 in March.

Employment in general merchandise stores grew by 12,000 over the month. This industry has added 41,000 jobs over the past 6 months with all of the growth occurring in other general merchanise stores, such as warehouse clubs and dollar stores.

Transportation and Warehousing

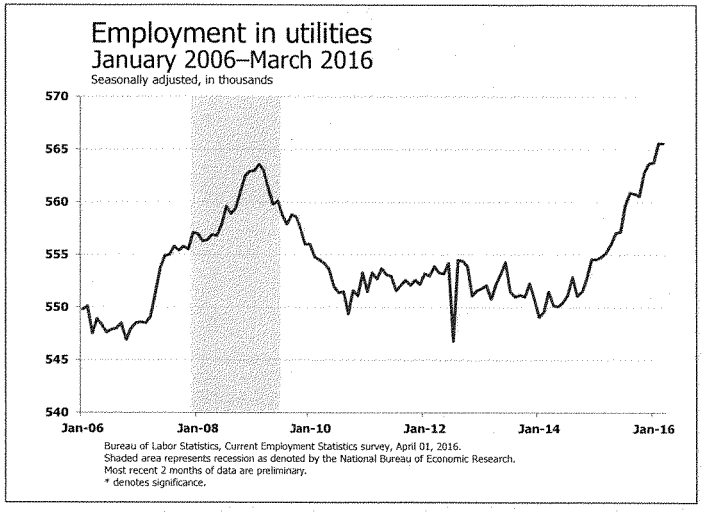




Employment in transportation and warehousing changed little in March (-3,000). Over the year, however, the industry has added 53,000 jobs.

Rail transportation shed 3,000 jobs in March, marking the 12th consecutive month of job losses. Over the year, employment in rail transportation has declined by 29,000, or 11.9 percent.

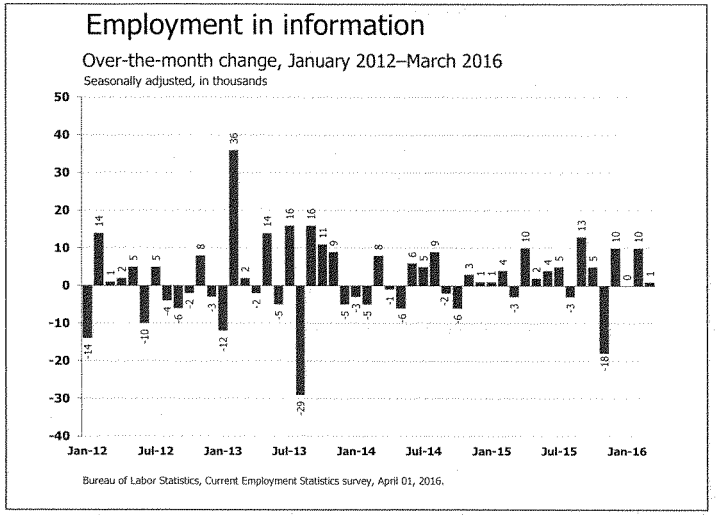
Utilities



Employment in utilities was unchanged in March.

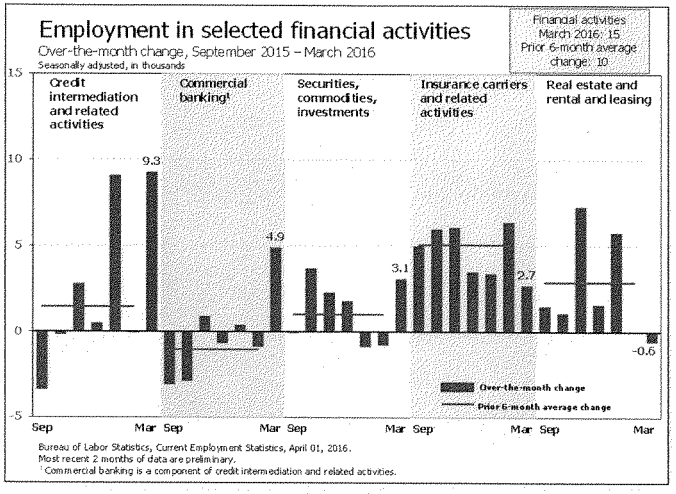
Summary | Mining & Logging | Construction | Manufacturing | Trade, Wholesale Retail | Transp., Warehousing & **Utilities** | Information | Financial Activities | Professional & Business Services | Private Education & Health Services | Leisure & Hospitality | Other Services | Government

Information



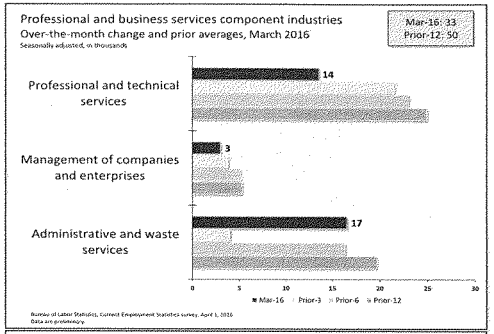
Information employment was essentially unchanged in March (+1,000). Over the last 12 months, employment in this industry has edged up 39,000.

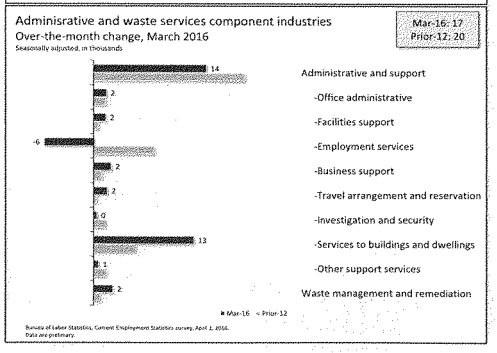
Financial Activities



Financial activities employment continued its upward trend in March (+15,000). Among the component industries, credit intermediation and related activities gained 9,000 jobs, about 5,000 of which were in commercial banking. So far this year, credit intermediation and related activities has added 18,000 jobs, the most among the major components within financial activities.

Professional and Business Services

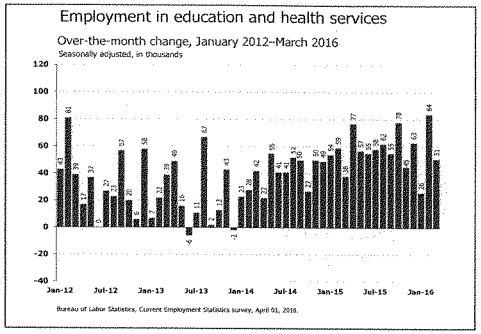


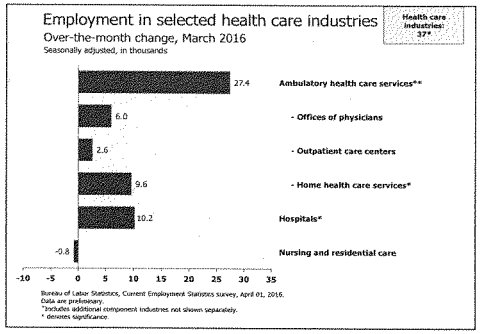


Professional and business services employment changed little in March (+33,000), weaker than the industry's prior-12 month average monthly change.

The March employment movement was split between administrative and waste services (+17,000) and professional and technical services (+14,000). Among the professional and technical services component industries, employment in management and technical consulting services continued to trend up (+7,000). Within administrative and waste services, services to building and dwellings added 13,000 jobs, while employment remained essentially unchanged in temporary help services (+4,000).

Private Education and Health Services



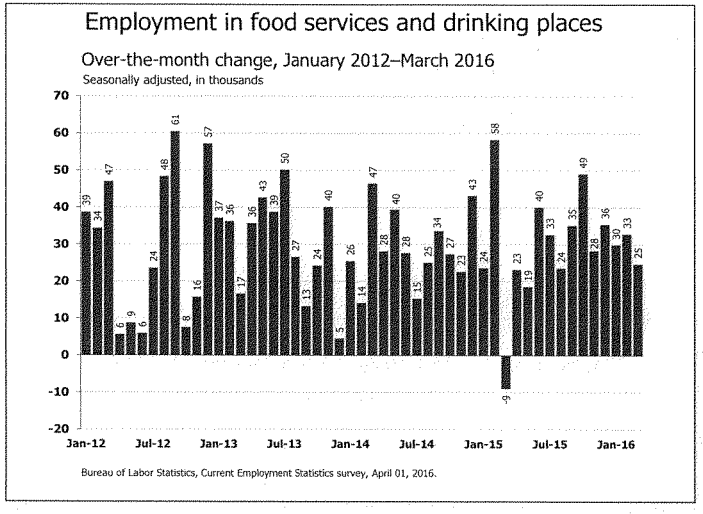


Employment in education and health services increased by 51,000 in March. Within the industry, health care added 37,000 jobs over the month, while employment in private educational services (+7,000) and in social assistance (+7,000) continued to trend up.

Ambulatory health care added 27,000 jobs in March, with home health care services adding 10,000. Employment in the industry has increased by 85,000 over the last 12 months, and the industry has accounted for 30 percent of the jobs gained in ambulatory health care services over the past year.

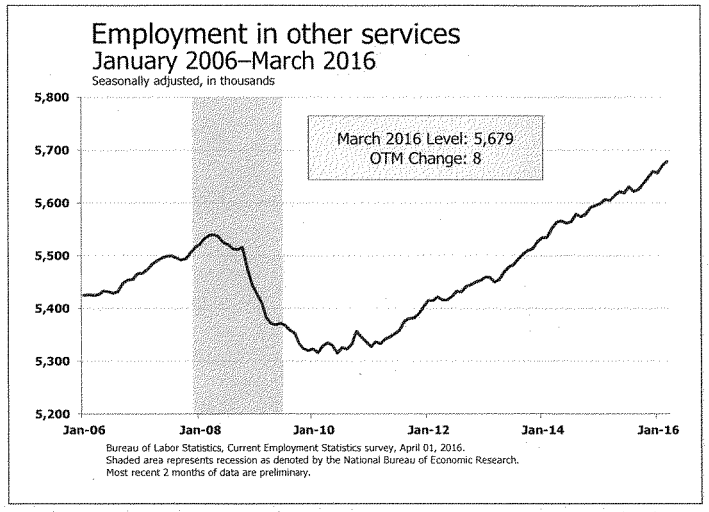
Hospital employment continued to grow in March, adding 10,000 jobs. In the last 12 months, employment in the industry has increased by 183,000, accounting for about 36 percent of the job gain in health care over the same period.

Leisure and Hospitality



Employment in leisure and hospitality continued to trend up in March (+40,000). Food services and drinking places employment also continued to trend up (+25,000). Over the last year, food services has gained 374,000 jobs, accounting for almost 80 percent of net growth in leisure and hospitality during the same period.

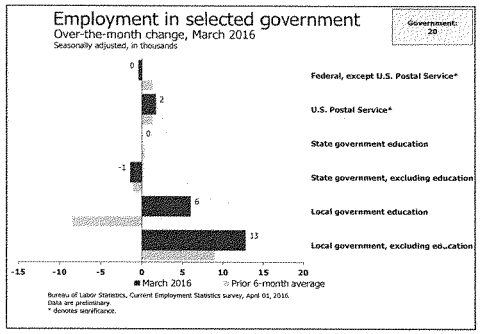
Other Services

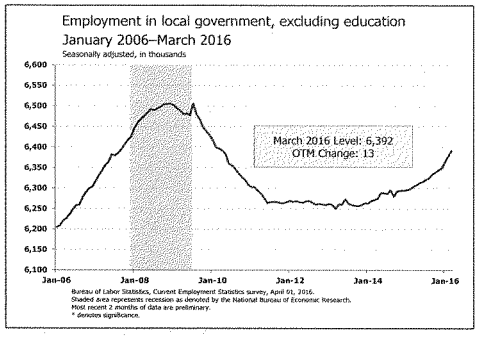


Employment in other services changed little in March (+8,000). Over the year, other services added 74,000 jobs, with personal and laundry services accounting for 47 percent of the increase.

Summary | Mining & Logging | Construction | Manufacturing | Trade: Wholesale Retail | Transp., Warehousing & Utilities | Information | Financial Activities | Professional & Business Services | Private Education & Health Services | Leisure & Hospitality | **Other Services** | Government

Government





Government employment changed little in March (+20,000) and has increased by 121,000 over the last 12 months. Local government, excluding education accounts for 73 percent of the employment gain in total government over the past year. Over the same period, the federal government added 23,000 jobs and state government employment changed little (+6,000).

Summary | Mining & Logging | Construction | Manufacturing | Trade: Wholesale Retail | Transp., Warehousing & Utilities | Information | Financial Activities | Professional & Business Services | Private Education & Health Services | Leisure & Hospitality | Other Services | Government

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Current Employment Statistics Highlights

Detailed Industry Employment Analysis

Prepared by Staff of the National Estimates Branch
Current Employment Statistics Survey
U.S. Bureau of Labor Statistics

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Mr. COURTNEY. Again, we still have work to do to make improvements, but there is no question that certainly when people actually step up and figure out how to make it work, as in Connecticut, both in terms of cost and access, I think we can point to real tangible results.

Ms. Corlette, just to shift the conversation a little bit, we are also a State that was the first to adopt paid sick leave, of up to five days, very controversial when the State legislature passed it. There was a business survey that was just done recently. Three-quarters of employers now in the State support it.

I just wonder if you could talk about that sort of feature as a way of improving workplace coverage in health and wellness.

Ms. CORLETTE. Thank you, Congressman. So, in full disclosure, this is not my area of expertise, my area of expertise is health insurance. But as I did note earlier in my testimony, paid leave often – changes places year to year –as the most popular employee benefit that employees cite as something they appreciate about their employment.

I can really only speak as an individual about the importance of paid leave, and also as a mother, and how critically important it was to me after I had my children. I would also say as a consumer of goods and services, I would like to know that the people that serve me in restaurants and establishments are not working because they are sick because they cannot afford to take a day off to get better. So, that is the best I can do. Unfortunately, it is outside my expertise.

Mr. COURTNEY. That is fine. I appreciate that. What is interesting is the survey that took place that I mentioned a moment ago. A third of employees who were eligible to use the statutory paid leave did not even use it.

Again, the notion that it is just going to trigger this huge utilization, in fact has not happened, people are committed to their jobs, but like you said, they should not be forced to be there when they are too ill to do it at the highest level, and also to keep the public safe.

With that, I yield back, Mr. Chairman.

Chairman ROE. I thank the gentleman for yielding. Mr. Allen, you are recognized.

Mr. ALLEN. Thank you, Mr. Chairman. Obviously, we have tipped the scales with healthcare prevention toward healthcare prevention. In fact, one of the early meetings with the most recent president of our medical school in Augusta, I think he said then we were spending about 25 percent of every healthcare dollar on preventive, and about 75 percent on critical, and we could cut health care costs tremendously if we could just move that to 50–50. And he felt like that was possible.

Ms. McDonough, I have been very interested in what you have had to say about that, and congratulate you on your work.

You know –- we—The public ObamaCare exchanges are failing, as we all know. I actually introduced legislation, the *Transparency and Accountability of Failed State Exchanges*, H.R. 4262, it requires failed State exchanges to return unused Federal funds for deficit reduction, requires an audit of how Federal taxpayer dollars were spent.

In our own State, our governor was criticized for not opting to take the Federal dollars and to open up a State exchange, but he obviously knew. In Georgia, we have to balance our budget. He did not want to have to write a blank check. We know that Oregon now is wanting to opt out as well as Kentucky.

Mr. Zern, can you talk about your free-market competitive exchange and how it saves employers and employees money, and how that might help having these private exchanges influence employee choice for health care?

Mr. ZERN. Sure. Thank you for the question, Congressman. First I would start by establishing that our exchange is an employer sponsored group plan, compliant with ERISA. It has some core themes or governing areas to it that I would share. First is standardized plan designs that really help the employee navigate the various choices.

Secondly is multiple insurance companies offering networks, so there is different network options for the consumer from which to select. The third is around strong decision support tools.

If you think about consistent plan designs, multiple carriers with network options for the consumer, and strong decision support tools, what those really lead to is an outcome around the engaged consumer and the empowered consumer, making a choice that works for them personally and their family situation.

It addresses choice which all of our survey data shows that employees and employers want to offer more choice around plan designs, multiple networks, and then it gets to transparency around costs and quality, which is kind of the third key governing thought for me.

So, our exchange, as I mentioned in opening comments, is driving a 100 to 200 basis point reduction over the standard health care cost increase.

Mr. ALLEN. One thing I have found about the American people is they want choice, and that is the big problem with the mandatory government health care program.

We know in the business world and we talked about it—

Ms. FRANKLIN. Congressman, could I just tag onto that very, very quickly?

Mr. ALLEN. Yes.

Ms. FRANKLIN. One other element that I think is fundamental in the private exchange is that there are different geographic markets. In our experience when we moved to the exchange, is that not one carrier has the best price everywhere. By having the localities compete, there is an opportunity for better products and cost savings as well.

Mr. ALLEN. We are having problems in Georgia, frankly, because of the status of health of a lot of our citizens there and particularly in my district.

You know we know that the only way to bring down costs in the business world, which I have been a small business owner for years, is by competition. Of course, the health insurance industry, they are consolidating as we speak. There are less and less companies offering health insurance. There are companies who are also saying they are going to get out, they are not going to serve this area or this exchange. They are just making calls.

How do we –- And Mr. Zern I will start with you and we have just a few seconds How do we introduce competition back into the marketplace? For example, ophthalmology. To get your vision corrected, it used to cost $3,000. It is a couple hundred dollars today. How do we do that real quickly? You got 25 seconds.

Mr. ZERN. Sure. I would say that in our exchange absolutely the fundamental piece is promoting market competition amongst the insurers. Quickly, on behalf of our employers, when the announcement was made about the potential consolidation, we did two pretty significant surveys.

The information coming back from employers is they are kind of on a wait and see as to if consolidation happens, what they are going to, what that is going to mean, but none of them stopped advancing their health care strategies, not a single one.

Mr. ALLEN. Thank you very much, panel, and I yield back, Mr. Chairman.

Chairman ROE. I thank the gentleman for yielding. Ms. Bonamici, you are recognized.

Ms. BONAMICI. Thank you very much, Mr. Chairman, and thank you, Chairman Roe and Ranking Member Polis for holding this hearing, and thank you all for your testimonies. It has been great to hear about some of the innovative approaches and the work that several companies are doing to make sure that they have a healthy workforce.

My home State of Oregon has often been a leader in finding more efficient and effective ways to deliver health care and improve health outcomes. Following up on Mr. Courtney's comment, our Oregon legislature did just pass paid sick days, which is really important, to make sure that we have a healthy workforce.

We also in Oregon expanded Medicaid. A year between 2013 and 2014 saw a 63 percent drop in the number of uninsured in Oregon.

Recently, I visited a company called Provata Health in Oregon. It is an Oregon based health technology company, focused on workplace wellness, and they use digital technologies. They have an evidence-based series of wellness programs that are scientifically designed to create a healthier and more productive workforce. They have been the subject of peer reviewed studies and showed both increased cost savings and improved health outcomes.

I wanted to ask first Ms. Corlette, can you talk a little bit about how employers might evaluate the potential cost savings, and what kind of methodologies could be used to determine those?

Ms. CORLETTE. Thank you, Congresswoman. So, we are in an interesting time when it comes to workplace wellness programs. Right now, in the marketplace, it is like 1,000 flowers are blooming.

That kind of innovation is both very exciting and provides some great opportunities, but I also think it can be very difficult both for employers as well as employees to sort of tease out of this myriad of programs that exist, what are the tools and incentives that really work both to change behavior, get to better health outcomes, and ultimately get to a lower cost growth trend.

The truth of the matter is that the research out there is growing, but it can be very difficult to tease out what is working and what is not. I will say what we are seeing is first of all that wellness

programs that are tied to some sort of premium based or cost sharing based cost financial incentives have really not been shown by themselves to change behavior.

What does seem to work in terms of cost reduction, of course, are targeted disease management programs that really target, for example, people with diabetes or a heart condition, that kind of thing, with direct and personalized interventions.

Also, frankly, changing the environment. Google is a great example of a company that has experimented with different wellness things but one of the most effective things they found was in their cafeteria, they moved all the healthy options up front and took the unhealthy options and sort of hid them in the corners, they reduced the sizes of plates and bowls, and that has made a tremendous difference in people's nutrition and overall health.

Those kinds of environmental changes sometimes are very easy to do but can be incredibly cost effective.

Ms. BONAMICI. I know just a few days ago the Center for American Progress talked about some of the state initiatives. Can you talk a little bit about some of the successful state models that we have seen?

Ms. CORLETTE. Sure. The ACA has really sparked a number of really innovative and exciting payment and delivery system models that are happening at the State and local level.

Here is an area where I think employers are really critically important participants in those models.

What the ACA has done is brought big government purchasers like Medicare and Medicaid to the table, but from providers' perspective, when you have Medicare telling them to do one thing and the commercial carriers telling them to do something else, and Medicaid yet another thing, those signals can get very confusing and administratively, very burdensome.

When the signals are aligned and you are encouraging more efficiency, higher quality, that can lead to both better health outcomes and lower costs.

Ms. BONAMICI. I am going to try to get one more question in. We have a need for more healthcare literacy and the uniform Summary of Benefits and Coverage that was created under the Affordable Care Act, and I think it has made a difference.

Can you discuss how that tool for workers can help them make more informed decisions, and are employees more confident in selecting a health plan now that will fit their specific needs?

Ms. CORLETTE. Thank you. So, polling does show that the SBC or Summary of Benefits and Coverage, is consistently one of the most popular provisions of the ACA. I think people are really excited for sort of standardized, uniform information that just says okay, what does this plan actually do for me.

Ms. BONAMICI. Do the employers on the panel agree with that?

Mr. ZERN. Yes, very similar feedback.

Ms. BONAMICI. Terrific, thank you.

Ms. FRANKLIN. I would add that decision support tools that are made available also encourage that kind of education as well.

Ms. BONAMICI. Terrific. Thank you. My time has expired. Thank you, Mr. Chairman.

Chairman ROE. I thank the gentlelady for yielding. Mr. Messer, you are recognized.

Mr. MESSER. Thank you, Chairman. Fascinating conversation today. You know, as we look at how we can control costs in the world of health care, I think most of us would concede that one of the most important things we can do is turn every American who receives health care into a health care consumer, where they are actually making consumer decisions.

At the same time, Mr. Zern, as you highlighted in your testimony, you have over 150 million Americans getting employer provided health care. That is an important part of our system. You mentioned in your testimony that employers offering health care benefits are genuinely driven to promote health care awareness, reduce health care spending, ensure that employees and their families have comprehensive coverage and the like.

There has been a lot of discussion lately about the overall viability and future role of employer-based health care. I was hoping you could just highlight for the panel, how do consumers behave differently when coverage is provided by their employer versus when they purchase health insurance on their own?

Mr. ZERN. So, I will be able to speak from the employer side certainly. Health care is complex. Employees look to their employer to continue to educate and communicate with them around a variety of issues, whether it is plan design, whether it is network configuration changes, what type of wellness programs I should be accessing or thinking about.

The employer is, to me, exceptionally critical to continuing to advance the communication and the empowerment of the consumer.

We have—The next stage, I think, that we really have to tackle is how do we get information in the hands of the consumer at the point of service. Right so, when you look at the waste in our health care system, how do we start to address that. I think that is the next set, and you can see that innovation through mobility apps and different things of that nature.

The education piece from the employer to the consumer is a critical function for us.

Mr. MESSER. Following up on that, what are some of the obstacles preventing employers from signing up for private exchanges that you can identify?

Mr. ZERN. So I think, you know, to Ms. Franklin's comments earlier, a private exchange is a great solution for a particular client. I have been in health care consulting for close to 30 years. I have seen lots of different plan designs, and an active exchange, a private exchange is a really good one that drives consumer engagement, transparency, and choice.

So, I think we are going to continue to see the evolution of exchanges, both public and private.

Mr. MESSER. I might open it to both Mr. Zern and others on the panel, we are here obviously today in Congress, what could Congress do to enhance the opportunities or to eliminate barriers for employers to be engaged in private exchanges?

Mr. ZERN. I am happy to jump in on that one, representing our the employers who are our clients. I think there is a desire for trying to drive a little more simplicity in the system. So, that would

be an area that we would be happy to work with Congress on behalf of our employer community, too.

How do we simplify some of the regulatory issues that our employers have to face that can push them to look at other areas, whether it is active exchange or other areas of innovation within the health care ecosystem.

Mr. MESSER. I presume part of your point there is when it gets so complicated, the individual employer just throws up their hands and decides to—

Mr. ZERN. It can be a little frustrating.

Mr. MESSER. Yes. Anybody else?

Okay. Thank you. I yield back the balance of my time, Chairman.

Chairman ROE. I thank the gentleman for yielding. Mr. Hinojosa, you are recognized.

Mr. HINOJOSA. Thank you, Chairman Roe, and Ranking Member Polis. The health insurance landscape has changed tremendously for employers and employees since the *Patient Protection and Affordable Care Act* implementation.

Just last month, we celebrated six years since ACA's enactment and celebrated the 20 million previously uninsured Americans who now have access to quality, affordable coverage.

In my region of South Texas, from San Antonio down to the Rio Grande Valley, we have close to 200,000 families receiving tax credits to help pay for coverage. In 2009, prior to ACA, 40 percent of the families in my congressional district were uninsured. Today, in 2016, only 20 percent are uninsured.

We have made great progress in this large region that has been growing so fast. Today's hearing focuses on alternative insurance models for employer provided health coverage, but in my view, any changes to employer coverage must be handled carefully as over 147 million people currently rely on employer sponsored benefits for health needs.

As you well know, the governor and the Texas legislature did not embrace ACA in our State, and they did not allow expansion of Medicare, nor did they allow creation of the Texas health insurance exchange marketplace.

However, in spite of those actions, Texas saw 1,306,208 people enrolled in private plans for 2016 through the Texas exchange during open enrollment. I am encouraged that we are doing some things right and helping a lot of people who under the conditions that our ranking member, Bobby Scott, gave that could not afford it or had preexisting medical conditions, are now covered.

So, my question that I have goes to—I have my papers a little mixed up here, excuse me. To Sabrina Corlette. Based on your expertise, how can Congress work together with health care service providers to ultimately reduce the cost of health care experienced by patients?

Ms. CORLETTE. Thank you, Congressman. As I mentioned in my testimony, I think one exciting thing but often under publicized about the Affordable Care Act is that it really launched a number of experiments in payment and delivery system reform that are bringing both public purchasers, like Medicare and Medicaid, along with private purchasers, like employers and employer coalitions, together to start to work towards increasing health care value.

By that, I am talking about things like patient-centered primary medical homes. As the Chairman mentioned earlier, accountable care organizations. Efforts to really re-emphasize primary, lets really Primary care, start putting more accountability into the system, reduce unnecessary and wasteful care.

These experiments are still in early days, and so they are showing, so we are starting to see some results, but still more time needed needs to tell. One thing that was very exciting about this particular hearing is the role of the employer and particularly self-funded employers, and how influential they can be at the local level in really driving change towards value and value-based care.

Mr. HINOJOSA. I agree with you. I want to be sure that the record reflects that across all 38 states, that use healthcare.gov, in the final week of the 2016 open enrollment period, eight of the 10 local areas with the fastest growing enrollment numbers were in Texas. It included Corpus Christi, Harlington, Laredo, El Paso, Odessa, Midland, San Antonio, Abilene, Sweetwater, and Lubbock.

I am encouraged. I am an optimist and I believe if we can just tweak ACA a little bit, that we can make it work for so many more people, and with that, I yield back.

Chairman ROE. I thank the gentleman for yielding. Mr. Grothman, you are recognized.

Mr. GROTHMAN. Thank you very much. I guess what we are coming down to is what can we do to make health care affordable. Yes, I strongly agree with Ms. Corlette that we are in the beginning stages of that. I think there are a variety of companies out there, Serigraph owned by John Torinus, in my neck of the woods, who have already found ways to greatly reduce the cost of their health care for employees.

I give a couple of you guys, if you can kind of rattle off what your total costs, not just the cost to the employer, but the cost to the employer plus employee is, in each one of your businesses, or if you don't have I guess—I guess you are all businesses of one nature or another.

We will start with Ms. Corlette since I just finished up with her. What is the total cost per employee at Georgetown University?

Ms. CORLETTE. I am sorry, sir. I actually do not know. I am not here to represent the university.

Mr. GROTHMAN. You will look into it? It is an important number. We should all know that. Ms. McDonough, what is the cost for health care at Fitbit per employee, in the programs that you cover?

Ms. MCDONOUGH. Unfortunately, I am also not able to speak to that. I do not sit within the H.R. organization.

Mr. GROTHMAN. Mr. Zern, do you know?

Mr. ZERN. Unfortunately not.

Mr. GROTHMAN. We need new witnesses. Ms. Franklin, do you know for Hallmark, what is your total cost—

Ms. FRANKLIN. Yes, sir. I pay those bills. It is about $9,500 $9,800 per employee per year.

Mr. GROTHMAN. That includes the cost the employee is paying?

Ms. FRANKLIN. No, that is just the Hallmark cost.

Mr. GROTHMAN. What is the cost per employee?

Ms. FRANKLIN. You know, I do not have that on an average basis because employees can enroll in different levels of coverage. I apologize.

Mr. GROTHMAN. You should keep track of that. It is a little bit embarrassing. What I wanted to do was talk about the difference between costs in corporations, what they are, and costs in government, costs in Medicare, and what they could be. What they could be if you combined an HSA with a wellness program, with an onsite clinic, and you did some sort of co-pay so your employees could shop for the lowest cost health care.

Since none of you know the answer to this, which you all should, since you are experts in the field, I can tell you I think a lot of companies could drop their total costs from about $20,000 to $12,000 per employee. It would be a difficult thing for the government to do since the government is so big, but I think if you had your own onsite clinics without the incentives to send people to expensive specialists, if you get a little bit wellness, even an HSA, so people had a little bit incentive not to run to the doctor at the drop of a hat, you would be amazed how much you four could find a drop in health care costs. It can be done by nonprofits, too.

I think Ms. Corlette, if you get involved in Georgetown's health insurance, I think you would find you could save a lot. There are a lot of universities today that claim they need more money and tuition is so high, but you might find, Ms. Corlette – I recommend you should read Mr. Torinus' book. You might find you could save $6,000 or $7,000 per employee at Georgetown and not have those kids graduating with such excessive debt.

Since people do not know that, I guess I will yield back the remainder of my time. That is what you should focus on, total cost including cost paid for by the employee in your businesses, and see what you can do to drag that down.

Thanks much.

Chairman ROE. I thank the gentleman for yielding. Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman. Following up on my colleague Representative Bonamici's comments about health literacy, Ms. Corlette, I wanted to relate some experience in my home State of California.

Covered California recently announced—Covered California is the name of our exchange—recently announced that its contract with insurers for plan years 2017 through 2019 will include expanded tools to help consumers make their choice in plans that is best for them.

Can you discuss how improving health literacy is a tool for workers to make more informed health care decisions?

Ms. CORLETTE. Absolutely. There are a number of exciting components to that Covered California contract for 2017 that include both more support for consumers to make smart choices but also really starting to align incentives for insurance companies to start to deliver better value. So, I commend California for really being the leader in this area.

On the issue of health insurance literacy, what we have now learned after a few years of enrollment through the health insur-

ance exchanges is that there really is not much health insurance literacy in this country, unfortunately.

Part of that stems from the fact that health insurance is such a complicated product. You are talking about premiums, deductible, co-insurance, co-payments, network issues, benefits. It is just very, very complicated.

Then you couple that with once you are enrolled, figuring out where is the appropriate place to get care. All of these things require a tremendous amount of knowledge on the part of the consumer.

One of the things the ACA has tried to do is provide more tools to consumers such as the Summary of Benefits and Coverage, to help them make informed decisions, but we are still a long, long way away from really getting to the decision support tools that are needed.

Mr. TAKANO. This may be an obvious question, but I think it is important for us to kind of get the thinking out there for the public.

I want to ask you a follow up. How does improved health literacy help to keep costs in check?

Ms. CORLETTE. Well I think first and foremost, by helping people understand where an appropriate care setting is for a particular injury or illness or condition, that can help people get the right care at the right place at the right time.

For example, you should not go to the emergency room for a sore throat or if you got the flu, you should go to a primary care setting, and that can lower costs dramatically. That is just one example. Just educating people about where the right place is to get care for a particular condition is important.

Mr. TAKANO. Because people who have not been insured before really do not know the different aspects of a health care system.

Ms. CORLETTE. That is right.

Mr. TAKANO. They need to learn these things, these terms, co-pay, co-insurance, all new to someone who has not really been insured before.

Had we not acted and passed the ACA, do you believe premiums for workers likely would be higher than they are today if we had not acted?

Ms. CORLETTE. Since the ACA was enacted, we have had the slowest growth in health care prices in just about a generation. It has really been remarkable. Some attribute that to the ACA. Some say it is the economy and other factors. We certainly have seen much, much slower growth than we had prior to the ACA.

I think that one of the other exciting things about the ACA are these multi-payer efforts where private purchasers are pulling together with Medicaid and Medicare to start to get more efficiencies into the system. Those are still in the early stages, and need some time to bear fruit. I am hopeful that we can, as you say, bend the cost curve for the long term.

Mr. TAKANO. One thing we know for sure is the sky did not fall, the world did not end, and we are not seeing lots of people being put out of work, lots of full-time people being moved into part-time jobs, all these claims that were made pointing to a dire disaster have not occurred.

Ms. CORLETTE. Quite the opposite. We are seeing job growth, really strong foundation of an employer-sponsored health care system.

Mr. TAKANO. Thank you very much, and I yield back my time.

Chairman ROE. Thank you, Mr. Takano. I will now yield to myself for five minutes. Why do companies form wellness programs? Well I think they do that, which is what the subject of this was today, to lower costs and improve the health care for their employees. I think that is why we do it. It makes sense to do it.

Just to point out something, I think the way you do that, and you have all clearly pointed out, is empower consumers, transparency, and quality. If you do those things, people can shop, and Americans are the best shoppers in the world. We will drive across five lanes of Interstate to get gas two cents a gallon cheaper. I know if we have the knowledge, we absolutely will make smart consumers.

I am a smart healthcare consumer. I have an HSA. What did the Affordable Care Act do? It discouraged consumerism, me being able to be in charge, not the insurance company, not the government, and one of the things you can do tomorrow, we could do tomorrow, is allow people to shop.

In other words, I am forced right now to buy ten essential health benefits, half of which I do not need. We need to allow consumers to purchase what they and their family can afford and what they need.

Let me just tell you what has happened in the real world, this all sounds great. In the real world, in the hospital where I practiced and taught at the medical school, 60 percent of the uncollectible debt in that hospital are people with insurance. Why? To meet these benchmarks of affordability, you raise the co-pays and out-of-pockets so high that people cannot afford it.

Now, it is left to providers, me and the hospitals, to provide that care when people cannot pay. If you have a $5,000 out-of-pocket, and you are a police officer where I live making $35,000 a year, it might as well be $100,000 out-of-pocket. You do not have the money to pay it.

We have to factor that in and figure out how not to do that. I think having consumers decide what they need to buy is the way.

Medicare, for instance—Medicaid, I mean for instance, we tried that experiment 20 years ago. Right now with the Federal Government running a deficit and paying all the bills, it looks fine, except the quality of care for Medicaid patients in many cases is actually less than people with no insurance. I find that abhorrent that we have people in this country with Medicaid that get a lower standard of care than other people. I think that is absurd. We need to reform that program before we expand that program. It almost bankrupted our State of Tennessee, which is why we have not expanded it yet.

Just a few things like that. I want to get back to a couple of questions that I would like to ask. By the way, the exchanges, which I found amazing, you all have set up these private exchanges at zero cost to the taxpayers, and we literally have flushed billions down the drain with the public exchanges.

By the way, one of them was Oregon, Hawaii. I could go on and on. The co-op's, almost half, over half of them are bankrupt and out of business. We need to let the private sector do this. They have done it very well at no cost to the taxpayers.

I wanted to say those few things just to get started. First, Mr. Zern, I want to go to you, and Ms. Franklin, both. Do you see these private exchanges expanding? In other words, you went from a system where you were self-insured to an insurance plan. Did you see that happening? Is that going up? I love the idea of these private exchanges.

Mr. ZERN. We certainly see continued steady growth in the exchange portfolio, and across the definition of exchanges, we absolutely expect to see continued growth, not only within ours but just as the industry defines exchanges and what is happening in the private health care exchange.

Chairman ROE. Why do you, Ms. Franklin—because when I was mayor of our local city, we had 1,000 employees, 1,500 teachers or so, and we were self-insured. What reason did you make at Hallmark to switch from a self-insured plan to—

Ms. FRANKLIN. The primary model that Aon has used is a fully insured model. Part of that model is to put the responsibility and accountability to the carriers as they seek innovation in health care.

To your specific question about the growth of this program, I do think—we have seen with our employees coming into the workforce, they value choice, they do not want one-size-fits-all, they appreciate being able to learn and customize a program that meets their needs.

Chairman ROE. I think by allowing consumers to have that voice and choice you have empowered them. I think there is no question about that.

The other thing I want to get in my little bit of time left, and this goes to maybe Fitbit, we need data to make clinical decisions. I mean I have to have that to make a rational clinical decision.

Ms. Corlette, I certainly understand where you are coming from with maybe someone who is coerced into doing something, we do not want that either.

We also need that data to be able to make decisions about are we doing the right thing. Otherwise, we keep doing, as Mr. Polis just said, at least some of these wellness programs may not work, and a gym membership is not a wellness program.

How do we protect the data so I can use it? I don't know what My cholesterol is my cholesterol. I could put it out there you wouldn't know it was Phil Roe.

Ms. MCDONOUGH. Thank you for the question. Fundamentally, I think it goes back to what you suggested, which is giving the consumer the choice to who and when and what data they share and with whom. There is a responsibility on Fitbit in this case to make sure that the data is secure and privacy is respected, and then by giving the employee or the individual the availability to share that data with their practitioner in the future so that they can have a better and more informed conversation, I definitely think is where the market is growing, given it is empowering the consumer and also the practitioner to be able to have that conversation.

Chairman ROE. I am going to gavel myself, I am over time. I want to thank the witnesses today. You all have been terrific. I have thoroughly enjoyed this. It is always nice to have a hearing you know something about, which is health care. I really enjoyed hearing what you had to say. I think it has been very beneficial.

We want to continue this discussion, and I want to thank you all for taking time to prepare to come today. At this point, I would like to ask Mr. Polis if he has any closing remarks.

Mr. POLIS. I will be brief. Thank you, Mr. Chair. Thank you to our witnesses for a very thoughtful and thought provoking discussion about how we can reduce costs, improve health outcomes in our employer-based health care system. Employer-sponsored insurance has been very popular, is very popular, will likely remain very popular.

We need to do everything we can to make sure that businesses and health care consumers have the right incentives to provide additional wellness based options and new programs to employees to help save costs and to make workers healthier.

I am excited about the role and the potential of technology and data to be very central to the decision making process at the employer level and within private exchanges as well.

It is heartening to see companies that are taking a close look at new and more efficient models for delivery, that can cut costs and improve outcomes.

I think we only scratched the surface today, Mr. Chair, and look forward to a lot more information for policymakers to make informed decisions about how we can encourage these kinds of activities in the marketplace, and I yield back.

Chairman ROE. I thank the gentleman for yielding. Just to finish up, I agree with much of what Mr. Polis said. We have created a system in the public system, and Ms. Franklin has a premium support, basically, it is a defined contribution for health care. You get to choose as a consumer which one of those.

Mr. Zern clearly pointed out that consumers will decide where their providers, where they go to the hospital, what doctors they see, what medications they can receive.

That is empowering people to make those decisions. We need to do more of that. What we have in Medicaid and Medicare is an archaic out of date system, and it needs to be completely redone, it is completely archaic. I mean we have a Medicare system that has an A, B, C, and D, and the day I turned 65, nothing happened except I got 65, and now I had an alphabet to go through about what kind of health care I wanted. I am exactly what I had the day before.

Those are the kinds of things I think this hearing—you have really ferreted it out very, very well. I do believe, absolutely believe, that the wellness part and one of the questions I did not get to ask was how do we take this technology and do we—in a big company, at Georgetown, where they are highly educated people, it is really pretty easy to do.

As I walked into the office today, I walked by a lot of people who are not very sophisticated, and I have lived in areas that are not, and I want to know is how do we get that information down to

where it can make a bigger impact, which is our lower income people and other folks.

I think we did not delve into that, and maybe that is a subject for another hearing. I think it is critically important. That is where your biggest gains will quite frankly be.

With nothing further, I appreciate very much you being here. The hearing is adjourned.

[Additional submissions by Dr. Roe follow:]

Congress of the United States

Washington, DC 20510

June 19, 2015

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

Submitted Electronically via Regulations.gov

Re: RIN 3046-AB01
Proposed Rule on Amendments to Regulations under the Americans with Disabilities Act

Dear Ms. Wilson:

We respectfully submit these comments in response to the Notice of Proposed Rulemaking ("NPRM," "proposed rule") regarding Amendments to Regulations under the *Americans with Disabilities Act* ("ADA"), as published in the *Federal Register* on April 20, 2015.[1] As Members of Congress, we write to express our concern with the Equal Employment Opportunity Commission's ("EEOC") disregard for current law in this most recent proposal to revise ADA regulations to address workplace wellness programs.

Prior to the passage of the *Patient Protection and Affordable Care Act* ("PPACA") in 2010, employers were able to provide a discount to employees of up to 20 percent off their health insurance premiums for making healthy lifestyle choices under the *Health Insurance Portability and Accountability Act* ("HIPAA"). After companies saw success with these programs, Congress increased the discount and provided reinforced statutory authority for premium discount wellness programs in PPACA—one of the few bipartisan provisions in the law.

Despite the clear authority in statute to provide premium rewards for wellness programs, EEOC's interpretation and enforcement of workplace wellness programs has been inconsistent and, at times, contrary to existing law and regulation. On January 6, 2009, EEOC's Office of Legal Counsel stated, "employers may offer inducements to encourage voluntary participation in wellness programs . . . so long as any financial inducements do not exceed the 20 percent limit

[1] Amendments to Regulations under the Americans with Disabilities Act, 80 Fed. Reg. 21659 (proposed Apr 20, 2015) (to be codified at 29 C.F.R. pt. 1630).

set forth in the final regulations implementing [HIPAA]."[2] On March 6, 2009, this guidance was rescinded. Five years later on October 27, 2014, and without any subsequent guidance, EEOC filed suit against an employer that was operating lawfully under PPACA and offering financial rewards to employees and their spouses or dependents for making healthy lifestyle choices.[3] EEOC sent a confusing message to employers—reliance on PPACA's authorization of wellness programs does not mean employers are safe from EEOC's litigation.

We appreciate that EEOC responded to Congress and employers by issuing this proposed rule, intended to provide clarity to employers about how EEOC believes the ADA applies to employee wellness programs. However, the proposed rule is inconsistent with both current law and the bipartisan intent of Congress and fails to clarify important issues.

Cap on Premium Reward for Wellness Programs

EEOC has no statutory or jurisdictional authority to propose to cap the maximum premium award. In the NPRM, EEOC attempts to limit the premium reward an employer may offer an employee to 30 percent of the cost of the premium. EEOC asserts its authority to regulate workplace wellness programs is provided pursuant to the ADA, specifically whether employee medical examinations and inquiries for a workplace wellness program are "voluntary." However, the statutory language of PPACA is explicit: employers may use workplace wellness programs to incentivize employees to make healthy lifestyle choices by offering a 30 percent premium reward and the Secretaries of Labor, Health and Human Services, and the Treasury ("tri-agency Secretaries") have the authority to increase the premium reward to 50 percent.[4] The tri-agency Secretaries exercised this authority and increased the maximum premium reward amount for tobacco cessation programs to 50 percent in regulation.

In January 2009, EEOC addressed the issue of whether premium rewards render wellness programs involuntary, and adopted the HIPAA premium reward level because, "[b]orrowing from the HIPAA rule is appropriate because the ADA lacks specific standards on financial inducements, and because it will help increase consistency in the implementation of wellness programs."[5] We agree with EEOC's January 2009 interpretation of the ADA. In the future, if the tri-agency Secretaries exercise their authority to increase the maximum reward percent allowed, employers would again find themselves in a legally confusing bind—remain under the cap required by EEOC or comply with PPACA and risk litigation from EEOC.

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[2] U.S. Equal Emp. Opportunity Comm'n Off. of Legal Couns., ADA: Disability-Related Inquiries and Medical Exams/Mandatory Clinical Health Risk Assessment (Jan. 6, 2009), *available at* http://pdfserver.amlaw.com/cc/WellnessEEOC2009.pdf

[3] U.S. Equal Emp. Opportunity Comm'n v. Honeywell Int'l., Inc., No. 14-CV-4517, 2014 U.S. Dist. LEXIS 157945 (D. Minn. Nov. 6, 2014).

[4] "The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available . . . to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate." Patient Protection and Affordable Care Act § 1201, 42 U.S.C. 300gg-4(j)(3)(A) (2010).

[5] U.S. Equal Emp. Opportunity Comm'n Off. of Legal Couns., ADA: Disability-Related Inquiries and Medical Exams/Mandatory Clinical Health Risk Assessment (Jan. 6, 2009), *available at* http://pdfserver.amlaw.com/cc/WellnessEEOC2009.pdf

Instead of setting a cap of a 30 percent maximum reward in its proposed rule, EEOC should tie the maximum permissible premium reward to the percentage set by the tri-agency regulations—the regulators with statutory authority to make these adjustments.

Cap on Premium Reward for Tobacco Cessation

The proposed rule's maximum premium reward amount of 30 percent for tobacco-related wellness programs that include a tobacco test is inconsistent with current law. The proposed rule limits to 30 percent the incentive an employer may provide an employee for a wellness program where there is a "disability-related inquiry" or "medical examination"—including tobacco testing. The proposed rule allows a 50 percent incentive if the wellness program only requires self-attestation, without a related exam or medical confirmation. However, currently the tri-agency regulations extend the maximum premium reward amount to 50 percent "for health-contingent wellness programs designed to prevent or reduce tobacco use."[6] A health-contingent wellness program is defined as "a program that requires an individual to satisfy a standard related to a health factor to obtain a reward . . . ."[7] Accordingly, a health-contingent wellness program could require the employee to complete a tobacco test before being eligible for the premium reward.

Employers have reason to test employees for tobacco use and not simply rely on good faith. Several studies have found individuals significantly underreport their tobacco use when asked to self-attest. For example, in 2014, anonymous national surveys show 18 percent of the adult population in Iowa smokes cigarettes, but Wellmark BlueCross BlueShield, a company that sells more than 75 percent of the individual health insurance policies in Iowa, stated only seven percent of their customers admitted to smoking.[8] In another national survey conducted by a nonprofit health organization, one in 10 smokers admitted to lying about their tobacco use to their physicians.[9]

As the proposed rule states, wellness programs are designed to "improve employees' health and reduce health care costs . . . ."[10] It may be difficult for an employer to help encourage employees to stop using tobacco products if employers are prohibited from confirming the accuracy of the employee's tobacco use if they offer a 50 percent premium reward to employees—the very employees who would benefit from such a program. EEOC should mirror the tri-agency regulations and allow employers to test for tobacco use even if they provide premium rewards that are greater than 30 percent.

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[6] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33167 (Jun. 3, 2013).
[7] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33161 (Jun. 3, 2013).
[8] Tony Leys, *Why Some Iowans are Lying About Tobacco Use*, Iowa City Press-Citizen (Jul 30, 2014), *available at* http://www.press-citizen.com/story/news/local/2014/07/29/iowans-lying-tobacco-use/13347559/
[9] Melissa Romero, *One in Ten Smokers Lies to His or Her Doctor*, Washingtonian (Jan. 17, 2012), *available at http://*www.washingtonian.com/blogs/wellbeing/health/one-in-ten-smokers-lies-to-his-or-her-doctor.php
[10] Amendments to Regulations under the Americans with Disabilities Act, 80 Fed. Reg. 21660 (proposed Apr 20, 2015) (to be codified at 29 C.F.R. pt. 1630).

Definition of Reward

The proposed rule would expand the statutorily-set definition of "reward" to include "in-kind" rewards—a definition inconsistent with current law and Congressional intent. Specifically, the NPRM discusses the premium reward in terms of "incentives," defining it to include "both financial and in-kind incentives, such as time-off awards, prizes, or other items of value."[11] PPACA allows employers to incentivize employees to make healthy lifestyle choices by providing a premium reward for participation in the workplace wellness program. As defined in PPACA, "[a] reward may be in the form of a discount or rebate of the premium or contribution, a waiver of all or part of the cost-sharing mechanism . . . the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan."[12]

To require employers to calculate "in-kind" rewards in addition to premium rewards would be administratively burdensome on employers and could discourage them from offering employees access to wellness programs. For example, if an employer offers what the Internal Revenue Service deems to be a de minimis, non-taxable reward (such as a t-shirt or a coffee mug), it is unclear if EEOC's proposed rule would still require employers to assess and attach a monetary value to that reward as compensation. Other rewards employers offer, such as an extra paid time off or a day in street clothes instead of the company uniform, may be even more difficult to assign value than de minimis rewards. The difficulty assigning a monetary value to these benefits is one of the reasons Congress does not require employers to include anything but the premium reward, or surcharge, toward the maximum reward amount. EEOC should not expand this definition.

During the Senate Committee on Health, Education, Labor, and Pensions ("HELP Committee") executive session on July 13, 2009, Senator Tom Harkin (D-IA) stated the wellness provision "allows employers to reward employees by as much as 30 percent *of a premium discount*, and then it allows the Secretary to increase this reward to 50 percent if deemed appropriate" (emphasis added).[13] During consideration of a similar provision in the Senate Committee on Finance, on September 30, 2009, the reward is discussed in the terms of a discount or surcharge of the premium several times by both Democrat and Republican Senators.[14] Congressional intent is clear: the maximum reward amount is to apply only to a premium discount, or surcharge, and should not be applied to other so-called "in-kind" rewards. EEOC should use the statutory definition of "reward" in PPACA and strike any reference to "in-kind" incentives.

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[11] Amendments to Regulations under the Americans with Disabilities Act, 80 Fed. Reg. 21660 (proposed Apr 20, 2015) (to be codified at 29 C.F.R. pt. 1630).
[12] Patient Protection and Affordable Care Act § 1201, 42 U.S.C. 300gg-4(j)(3)(A) (2010).
[13] *Affordable Health Choices Act: Executive Session Before the S. Comm. on Health, Educ., Lab., and Pensions*, 111th Cong. (2009) (statement of Sen. Tom Harkin).
[14] *Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform: Executive Session Before the S. Comm. on Fin.*, 111th Cong. (2009).

Employee-Only Coverage

The proposed rule significantly reduces the reward available to employees if a dependent or spouse participates in the wellness program by applying the 30 percent reward cap to the cost of the employee-only coverage and not extending it to the cost of dependent and spousal coverage.[15] PPACA allows an employer to reward an employee up to 30 percent of the cost of employee-only coverage or dependent or spousal coverage if the family members also participate in the wellness program. Specifically, the law states, "[i]f . . . any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled."[16] This is further established in the tri-agency regulations.[17]

We understand from discussions with EEOC that "employee-only" coverage was the only form of coverage contemplated in the proposed rule because it is the only form of coverage within the jurisdiction of the ADA. However, as written, the proposed rule effectively eliminates employers' ability to extend the premium discount to family members who participate in the wellness program. Requiring the employee reward be calculated on the cost of employee-only coverage is impractical for many employers because health insurance coverage for a family is sold as a single policy and not as individual policies for each member of the family. It would be administratively and mathematically complex for employers to calculate the cost of individual health insurance plans for every employee, spouse, and child. Therefore, EEOC should make clear in the final rule that because the ADA does not have jurisdiction over dependent and spousal coverage, employers should follow the caps dictated in PPACA and the tri-agency regulations when the health insurance plan provides dependent and spousal coverage.

Affordability Standard

The proposed rule solicits input on whether EEOC should use PPACA's affordability standard to determine if a wellness plan reward renders participation involuntary for purposes of the ADA. PPACA's affordability standard requires only that large employers offer full-time employees at least *one* affordable health insurance plan, or pay a penalty. PPACA does not require that *all* plans offered to an employee cost less than 9.5 percent of an employee's household income, nor does PPACA require that an employee *choose* the most affordable plan. Under EEOC's proposed rule, if an employee were to choose the more comprehensive (and more expensive) health insurance plan, and chose not to participate in the company's wellness plan to get a premium reward, the health insurance plan would still meet PPACA's affordability standard, but would violate the ADA. Effectively, EEOC would require that all health insurance plans *plus* wellness plans an employer offers each employee meet the

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[15] "[T]he maximum allowable incentive . . . may not exceed 30 percent of the total cost of employee-only coverage." Amendments to Regulations under the Americans with Disabilities Act, 80 Fed. Reg. 21668 (proposed Apr 20, 2015) (to be codified at 29 C.F.R. pt. 1630).
[16] Patient Protection and Affordable Care Act § 1201, 42 U.S.C. 300gg-4(j)(3)(A) (2010).
[17] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 78 Fed. Reg. 33162 (Jun. 3, 2013).

affordability standard—a standard that is far beyond the affordability standard contemplated in PPACA.

We believe it inappropriate for EEOC to regulate regarding PPACA's affordability standard. If Congress had intended for the affordability standard to impact the premium reward an employer may offer an employee for making healthy lifestyle choices, that standard would also have been included in statute. We are concerned that if EEOC implements an affordability standard it may chill employers from offering wellness plans, reduce employee choice of health plans, and make job-based health plans less generous.

ADA's Safe Harbor Provision for Insurance Plans

EEOC seeks to nullify the ADA's safe harbor provision for bona fide benefits plans via footnote in the preamble of the proposed rule.[18] The ADA explicitly does not prohibit or restrict a, "person or organization . . . from establishing, sponsoring , . . or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks . . . ."[19] Further, the U.S. Court of Appeals for the Eleventh Circuit held in 2012 that a wellness program may qualify as a "term[] of a bona fide benefit plan" for purposes of the insurance safe harbor.[20]

The proposed rule dismisses the statutory safe harbor provided in the ADA, stating that its existence would render the voluntary requirement for wellness plans to be "superfluous." However, some wellness plans are designed as a bona fide benefit plan with terms based on underwriting, classifying, or administering risks, and some are not. Put simply, EEOC should not rewrite statute and vacate court decisions through regulation. This provision in the NPRM should not be included in the final rule.

Effective Date

We request EEOC include an effective date in the final rule no sooner than plan year 2018 to provide employers with time to come into compliance with the final rule. Many employers have planned their health insurance and wellness plans for plan year 2016 and may have completed planning for the 2017 plan year by the time EEOC issues final rules under both ADA and the *Genetic Information Nondiscrimination Act* ("GINA"). Providing adequate time to employers to adjust their wellness programs to meet the new requirements under the ADA and GINA is essential to ensure a seamless transition and employer compliance.

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[18] Amendments to Regulations under the Americans with Disabilities Act, 80 Fed. Reg. 21662 (proposed Apr 20, 2015) (to be codified at 29 C.F.R. pt. 1630).
[19] Bradley Seff v. Broward Cty. Florida, 691 F.3d 1221 (11th Cir. 2012).
[20] Bradley Seff v. Broward Cty. Florida, 691 F.3d 1221 (11th Cir. 2012).

Conclusion

EEOC's proposed interpretation of the ADA and workplace wellness programs is inconsistent with the bipartisan intent of Congress. The ADA was enacted in 1990 and this year marks its 25th anniversary. PPACA became law 20 years later in 2010. If Congress believed the wellness provisions in PPACA to be discriminatory, or to violate the "voluntary" provision in ADA, it would have addressed these concerns in the statutory language. In fact, Senator Tom Harkin (D-IA), the lead author of the ADA, stated during consideration of the workplace wellness provision in the HELP Committee on July 13, 2009, "it does include those provisions to make sure that discrimination does not occur."[21] The wellness plan language was carefully crafted and enjoyed significant bipartisan support, passing the Senate HELP Committee with a unanimous vote of approval.

In response to EEOC's wellness program litigation, on March 2, 2015, the *Preserving Employee Wellness Programs Act* (S. 620, H.R. 1189) was introduced in both chambers of Congress to reaffirm existing law and Congressional intent in PPACA. The legislation would allow employers to offer employee wellness programs with a premium reward so long as it is within the levels set in statute by PPACA and in the tri-agency regulations, clarifying that an employee's spouse and dependents may participate in the program, and retaining EEOC's rightful authority to investigate and litigate complaints of employment discrimination. We strongly urge EEOC to take the same measured approach and consider this legislation as a path forward when finalizing the proposed rule.

We respectfully request EEOC follow the clear intent of Congress in PPACA, the subsequent tri-agency regulations, and the White House's support for workplace wellness programs and ensure any final rule promulgated by EEOC is consistent with PPACA and does not create any further confusion for employees and employers.

Sincerely,

Lamar Alexander
Chairman
Senate Committee on Health,
Education, Labor, and Pensions

Johnny Isakson
Chairman
Subcommittee on Employment and
Workplace Safety
Senate Committee on Health,
Education, Labor, and Pensions

[21] *Affordable Health Choices Act: Executive Session Before the S. Comm. on Health, Educ., Lab., and Pensions*, 111th Cong. (2009) (statement of Sen. Tom Harkin).

Mike Enzi
Chairman
Subcommittee on Children & Families
Senate Committee on Health,
Education, Labor, and Pensions

John Barrasso, M.D.
United States Senator

Roy Blunt
United States Senator

Tom Cotton
United States Senator

Orrin Hatch
United States Senator

David Perdue
United States Senate

Pat Roberts
United States Senator

John Thune
Unites States Senator

Lisa Murkowski
United States Senator

John Kline
Chairman
House Committee on Education and the Workforce

Tim Walberg
Chairman
House Subcommittee on Workforce Protections

Phil Roe, M.D.
Chairman
House Subcommittee on Health, Employment, Labor, and Pensions

Todd Rokita
Chairman
House Subcommittee on Early Childhood, Elementary, and Secondary Education

Joe Heck, D.O.
United States Representative

Mike Bishop
United States Representative

January 28, 2016

Submitted Electronically via Regulations.gov

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

Re: RIN 3046-AB02: Proposed Rule Amending Regulations Implementing the *Genetic Information Nondiscrimination Act of 2008*

Dear Ms. Wilson:

We respectfully submit these comments in response to the Notice of Proposed Rulemaking ("NPRM" or "proposed rule") regarding amendments to the regulations implementing Title II of the *Genetic Information Nondiscrimination Act of 2008* (GINA) as they relate to employee wellness programs, as published in the Federal Register on October 30, 2015. We strongly support the standards enumerated in GINA to protect the privacy of individuals and prohibit discrimination on the basis of genetic information, and we understand the Equal Employment Opportunity Commission's (EEOC) role in enforcing GINA. However, as members of the House Committee on Education and the Workforce, we submit this comment letter to express our concerns that aspects of the proposed rule are contrary to law and will undermine the effectiveness of employer programs designed to encourage employees to adopt healthy behaviors ("wellness programs").[1] Therefore, in our view, the proposed rule requires significant revisions.

Legal Background

As highlighted in testimony before the House Committee on Education and the Workforce, employers have developed and implemented wellness programs to improve the

[1] Along with Senate colleagues, we previously submitted a comment letter critical of provisions in EEOC's proposed rule regarding amendments to regulations under the *Americans with Disabilities Act* as they relate to employee wellness programs, as published in the Federal Register on April 20, 2015. Letter from Lamar Alexander, Chairman, Senate Committee on Health, Education, Labor, and Pensions *et al.* to Bernadette B. Wilson, Acting Executive Officer, Executive Secretariat, U.S. Equal Employment Opportunity Commission [hereinafter ADA Comment Letter] (June 19, 2015) (attached).

health of employees and their families, increase employee performance and productivity, and reduce overall health care costs.[2] Tamara M. Simon, testifying on behalf of the American Benefits Council, stated:

> [E]mployer-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.[3]

Wellness programs typically focus on health promotion and disease prevention and can be offered directly by the employer or insurer. To encourage participation, wellness programs may include rewards or incentives, such as insurance premium discounts, cash rewards, or free health club memberships.

There are two types of wellness programs: "participatory" and "health-contingent."[4] Participatory wellness programs either do not provide a reward or do not require a health benchmark to be completed in order to earn a reward. Reimbursement of a gym membership or rewards for attending free health seminars are examples of participatory wellness programs. In contrast, health-contingent wellness programs require a participant to satisfy a health standard before reward eligibility.

Health-contingent wellness programs are further broken down into "activity-only" or "outcome-based."[5] In an "activity only" health-contingent wellness program, the participant must complete a specific activity related to a "health factor,"[6] such as a walking or diet program, to earn any rewards. In an "outcome-based" health-contingent wellness program, the participant must maintain or achieve a certain health outcome to get the award, such as not smoking or reaching a targeted cholesterol level. If a participant has difficulty taking part in or completing a health-contingent wellness program due to a health factor, a waiver or "reasonable alternative standard" for reward qualification must be offered, such as compliance with a health educational program.[7]

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) generally forbids group health plans and group health insurance issuers from discriminating with respect to

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[2] *Legislative 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, *Before the House Subcomm. on Workforce Protections, Comm. on Educ. and the Workforce*, 114th Cong. (Mar. 24, 2015) (written testimony of Tamara M. Simon on behalf of the American Benefits Council at 1-2).
[3] *Id.* at 1.
[4] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans [hereinafter Tri-Agency Regulations], 78 Fed. Reg. 33158, 33160-33161 (June 3, 2013).
[5] *Id.*, 78 Fed. Reg. at 33161.
[6] Under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) and the *Patient Protection and Affordable Care Act* (PPACA), the "eight health-status related factors" or "health factors" are "health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability." *Id.*, 78 Fed. Reg. at 33158 n.2.
[7] *Id.*, 78 Fed. Reg. at 33163.

eligibility, benefits, or premiums based on a health factor.[8] However, the statute specifically exempts premium discounts or rebates offered in return for adherence to a wellness program from this prohibition.[9]

The *Patient Protection and Affordable Care Act* (PPACA) extended the HIPAA nondiscrimination protections to the individual market and expanded rewards for health-contingent wellness program participation.[10] Regulations issued by the Departments of the Treasury, Labor, and Health and Human Services (tri-agency regulations) in 2013 increased the maximum allowable reward from 20 percent (the original limit under HIPAA regulations[11]) to 30 percent of premiums for employee participants in health-contingent wellness programs and up to 50 percent for smoking cessation programs.[12] Under the tri-agency regulations, participatory programs are compliant with the nondiscrimination provisions as long as the program is made available to all similarly-situated individuals, regardless of health status.[13]

***Honeywell* Litigation and Legislative Response**

On October 27, 2014, EEOC filed a petition in the U.S. District Court for the District of Minnesota seeking a preliminary injunction to stop Honeywell International Inc. from implementing its voluntary employee wellness program. Despite clear statutory authorization for such incentives, EEOC argued Honeywell's program ran afoul of two statutes: the *Americans with Disabilities Act* (ADA) and GINA. Generally, the ADA prohibits mandatory medical examinations and inquiries, and GINA prohibits the involuntary collection of medical information from an employee's family member.[14] EEOC argued the wellness program's participation incentives made the program *involuntary* and therefore in violation of the ADA and GINA. On November 6, 2014, the district court denied the EEOC's petition, citing "great uncertainty" as to how PPACA, the ADA, and GINA are intended to interact.[15]

EEOC's posture in *Honeywell* has, in turn, wrought "great uncertainty" for employers trying to implement wellness programs intended to benefit their employees and reduce overall health care costs. In order to provide employers and employees certainty, the *Preserving Employee Wellness Programs Act* (H.R. 1189)[16] was introduced on March 2, 2015. The bill reaffirms that if an employee wellness program's financial rewards comply with PPACA and the tri-agency regulations, the program does not violate the ADA or GINA. The bill also clarifies that collecting medical information about an employee's family member who is also participating in the wellness program does not violate GINA. EEOC would retain the authority to investigate complaints of discrimination in the context of wellness programs, and to pursue

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[8] HIPAA, Pub. L. No. 104-191, § 2702 (1996).
[9] *Id.* § 2702(b)(2)(B).
[10] *Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, § 1201 (2010).
[11] Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75014, 75018 (Dec. 13, 2006).
[12] Tri-Agency Regulations, 78 Fed. Reg. 33158.
[13] *Id.* at 33163.
[14] ADA § 102(d)(4)(A), 42 U.S.C. § 12112(d)(4)(A); GINA § 202(b)(2), 42 U.S.C. § 2000ff-1(b)(2).
[15] *EEOC v. Honeywell*, 2014 WL 5795481, *5 (D. Minn. Nov. 6, 2014).
[16] Sponsored by Rep. Kline (R-MN).

litigation to enforce the ADA and GINA. EEOC's finalized ADA and GINA rules should comport with this commonsense legislation.

Cap on Premium Reward for Wellness Programs

The proposed rule's limits on premium rewards are inconsistent with PPACA. For outcome-based wellness programs, PPACA permits a "premium reward" of up to 30 percent (and up to 50 percent if the Secretaries of Labor, Health and Human Services, and the Treasury determine an increase is appropriate) of the total cost of coverage of an employee, a spouse, and any other dependents who are enrolled, as long as the dependents may participate fully in the wellness program.[17] The proposed rule limits all employer-provided rewards to 30 percent of the total cost of coverage of the employee and any enrolled spouses and/or dependents.[18] While this is an improvement on the ADA proposed rule, which only permits a 30-percent reward based on the cost of employee-only coverage,[19] the GINA proposed rule establishes a cap that may differ from the cap set by the three Secretaries. We therefore urge EEOC to tie its maximum permissible reward to the maximum set by the Secretaries, which may increase in future rulemaking.

Reward Apportionment

Under current law, most wellness programs apportion the incentive equally between the employee and spouse. Moreover, HIPAA, PPACA, and the tri-agency regulations do not require, or even contemplate, any specific apportionment of the incentive.[20] Nevertheless, the proposed rule invents a new formula for apportioning rewards.

PPACA mandates that "such [a] reward shall not exceed 30 percent of the cost of coverage *in which an employee or individual and any dependents are enrolled.*"[21] The statute further explains that 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 *(or the employee and any dependents are)* receiving coverage."[22] Thus, the total cost of coverage in which both the employee and dependents are actually enrolled is to be considered; rewards for self-only coverage and dependent coverage should not be considered separately.

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[17] 42 U.S.C. § 300gg-4(j)(3)(A).
[18] Genetic Information Nondiscrimination Act of 2008 [hereinafter GINA Proposed Regulations], 80 Fed. Reg. 66853, 66861 (Oct. 30, 2015).
[19] Amendments to Regulations Under the Americans with Disabilities Act [hereinafter ADA Proposed Regulations], 80 Fed. Reg. 21659, 21668 (Apr. 20, 2015) ("maximum allowable incentive for a participatory program ... or for a health-contingent program ... may not exceed 30 percent of the total cost of employee coverage"). Our comment letter criticized the ADA proposed rule for significantly reducing the incentive available to employees by only basing the 30 percent incentive cap on employee-only coverage rather than the total cost of employee and dependents coverage, as permitted under PPACA. ADA Comment Letter, *supra* note 1.
[20] The tri-agency regulations "do not set forth detailed rules governing apportionment of the reward under a health-contingent wellness program." Tri-Agency Regulations, 78 Fed. Reg. at 33162.
[21] 42 U.S.C. § 300gg-4(j)(3)(A).
[22] *Id.*

In contrast, under the proposed rule, the maximum reward for the employee is 30 percent of the cost of *self-only* coverage.[23] The maximum reward for the employee's enrolled spouse is 30 percent of the total coverage cost for the employee and participating spouse minus 30 percent of the cost of self-only coverage.[24] The folly of the proposed rule is evident even in EEOC's hand-picked example. In that example, the total cost of coverage was $14,000 and the self-only coverage cost was $6,000. Under the proposed rule, the wellness program's maximum amount of the total reward would be $4,200, the maximum reward for the employee would be $1,800, and the maximum reward for the spouse would be $2,400.[25] This is an absurd result: the spouse has more incentive to participate in the wellness program than the employee. Such a result is contrary to law and current regulations. Therefore, EEOC should discard the apportionment formula.

Wellness Program Design

PPACA requires that outcome-based wellness programs "shall be reasonably designed to promote health or prevent disease,"[26] and the tri-agency regulations elaborate on this requirement.[27] EEOC proposes a similar standard for all wellness programs that, if finalized, would raise significant conflicts and jurisdictional questions.[28]

First, the PPACA standard only applies to outcome-based wellness programs, while the proposed rule would apply to all wellness programs. Again, EEOC's proposal is contrary to unambiguous statutory language. Second, EEOC lacks jurisdiction to import this standard. GINA does not in any way address wellness program design, unlike PPACA. Without a statutory mandate, EEOC lacks the authority to regulate the content of wellness programs. Nevertheless, the proposal signals EEOC's far-reaching claim of jurisdiction to interpret and enforce the standard differently than it has been interpreted and enforced under PPACA and the tri-agency regulations. Consequently, under the enforcement regime envisioned by the proposal, EEOC will pass final judgment on the content and design of wellness plans. There is no evidence Congress intended to enable EEOC's novel seizure of jurisdiction.

Limiting Reward to Participating Spouses

Unlike PPACA, the proposed rule prohibits rewards for the employee's dependents other than a spouse.[29] Perversely, this disadvantages single parents. For example, a single mother who

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[23] GINA Proposed Regulations, 80 Fed. Reg. at 66861.
[24] *Id.*
[25] *Id.*
[26] 42 U.S.C. § 300gg-4(j)(3)(B).
[27] The tri-agency regulations state that a wellness program is "reasonably designed" if it has a "reasonable chance of improving the health of, or preventing disease in, participating individuals," "is not overly burdensome," "is not a subterfuge for discriminating based on a health factor," and "is not highly suspect in the method chosen to promote health or prevent disease." Tri-Agency Regulations, 78 Fed. Reg. at 33177.
[28] Under the proposed rule, a wellness program must be "reasonably designed," and it is "reasonably designed to promote health or prevent disease" if it has a "reasonable chance of improving the health of, or preventing disease in, participating individuals," "is not overly burdensome," "is not a subterfuge for violating Title II of GINA or other laws prohibiting employment discrimination," and "is not highly suspect to promote health or prevent disease." GINA Proposed Regulations, 80 Fed. Reg. at 66861.
[29] *Id.*, 80 Fed. Reg. at 66861.

has children covered under her health plan and eligible to participate in the wellness program could only receive a maximum reward of 30 percent of self-only coverage rather than 30 percent of the total cost of coverage of and these eligible dependents. It is unduly restrictive to prevent her children from qualifying for the incentive, benefiting from participation in a wellness program, and depriving the family of important savings.

Effective Date

Employers plan their wellness programs years in advance, and many will have completed planning for 2017 when the final ADA and GINA rules are published. An effective date earlier than plan year 2018 will be extremely disruptive and costly for employers that have chosen wellness programs which comply with current law and regulations. As requested in our ADA comment letter,[30] the ADA and GINA final rules should have effective dates that coincide with plan year 2018 to give employers enough time to come into compliance with the final rule.

Conclusion

We strongly support the protection of individuals' privacy and GINA's prohibition against discrimination on the basis of genetic information. We also recognize EEOC's role in enforcing this law. These important protections can be effectively maintained without needlessly complicating and discouraging wellness programs that already comply with PPACA and the tri-agency regulations. Moving forward, EEOC must ensure employers and employees have certainty and consistency in the rules governing wellness programs.

Sincerely,

JOHN KLINE
Chairman
Committee on Education and the Workforce

TIM WALBERG
Chairman
Subcommittee on Workforce Protections

PHIL ROE
Chairman
Subcommittee on Health, Employment,
Labor, and Pensions

[30] *See* ADA Comment letter, *supra* note 1.

National Coalition on BENEFITS

March 18, 2016

The Honorable Tom Price, M.D.
Chairman
Committee on the Budget
U.S. House of Representatives
207 Cannon House Office Building
Washington, D.C. 20515

The Honorable John Kline
Chairman
Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairmen Price, Kline, Upton and Brady:

The National Coalition on Benefits (NCB) is dedicated to preserving the benefits of millions of Americans who receive health insurance through employers. The coalition is comprised of major employer trade associations, representing large and small employers. NCB also includes many large employers with employees and retirees in all 50 states. We are writing to urge your support for strengthening the employer-sponsored health care system.

We are united around one central principle: we support employer-sponsored coverage in America and the federal Employee Retirement Income Security Act (ERISA) law that protects and enables coverage. Employers want to continue offering coverage for many reasons; not only to retain employees, but also to provide them with the right tools to remain healthy and productive. Surveys have shown that employees, retirees and dependents favorably view employer-sponsored coverage. At the same time, we welcome the discussion in the Task Forces on ways to improve the health of our communities, and we believe that employers remain a key to that improvement.

As you evaluate health care reform alternatives, we want to emphasize three important messages on employer-sponsored coverage:

First, over **175 million** Americans are enrolled in employer-sponsored coverage; a growing number according to a recently-released report from the Employee Benefit Research Institute. Moreover, according to a Kaiser Family Foundation Survey, 88 percent of workers report that health benefits are "extremely" or "very" important.

We urge you to protect ERISA and its role in fostering employer-sponsored coverage. As you seek to improve the health system, we ask that you work with us to promote simplicity and flexibility in the offering of

employer-sponsored health benefits. We are eager to have a discussion regarding how employer plans can further the goals of transparency and portability.

Second, we believe the ACA's 40 percent tax on health benefits must be repealed. NCB does not support such modification to the tax treatment of employer-sponsored coverage. There is no consistent evidence that taxing health benefits will result in savings to the health system. Instead, changes in the tax treatment of employer-sponsored benefits that adversely affect employers and employees will have a widespread impact and particularly be felt by individuals whose employers have an older workforce, or a workforce with employees and family members with chronic illnesses, or a workforce with employees who live in high-cost areas of the country. Further, the political challenge of enacting health care reforms will not be eased by creating a *de facto* tax increase for many employees.

Finally, we believe that greater innovations in employer-sponsored coverage may help reduce health care spending. Employers are adopting new strategies to improve the delivery of health care and are empowering employees and their families with more tools to help them avoid preventable chronic illnesses. Some are providing employees with on-site – or access to mobile or nearby – clinics to receive screening and routine services. Others are driving greater performance in provider networks. These are all innovations that can improve each and every community where employees live.

We support your efforts to strengthen the individual health coverage system, but not at the expense of the employer-sponsored system that is highly valued by the majority of Americans who receive their health coverage through employers today and is a critical source of innovation necessary to improve the health of our communities.

In closing, NCB looks forward to working with you and your colleagues to continue supporting and encouraging innovations in employer-provided health care coverage and to lower health care costs for both employers and employees and the communities in which they live.

Sincerely,

National Coalition on Benefits

c.c.: The Honorable Paul Ryan
The Honorable Kevin McCarthy
The Honorable Steve Scalise

SHRM
SOCIETY FOR HUMAN RESOURCE MANAGEMENT

April 13, 2016

The Honorable Tom Price, M.D.
Chairman
Committee on the Budget
U.S. House of Representatives

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives

The Honorable John Kline
Chairman
Committee on Education and the Workforce
U.S. House of Representatives

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives

Dear Chairmen Price, Kline, Upton and Brady:

On behalf of the more than 275,000 human resource professionals who are members of the Society for Human Resource Management (SHRM), thank you for your leadership on the health care reform taskforce. As you evaluate health care reform proposals, I urge you to support and strengthen the employer-sponsored health care system.

There are currently over 175 million Americans who receive health care coverage through their employer; this means more than half of all Americans get coverage at work. Employers recognize the importance of offering competitive employee health care benefits to recruit and retain a talented workforce, and to provide employees with tools and services to remain healthy and productive.

Many employers are adopting innovative strategies to improve health benefit offerings to their employees and some are providing tools to help employees be better consumers of health care. These innovative strategies will lead to employees taking an active role in the purchase of their care and, improved health outcomes for employees and their families. They also will eventually lead to lower overall U.S. healthcare costs. HR professionals have a significant opportunity to impact healthy lifestyle choices through employee education – an added benefit of employer-sponsored health care. More can and will be done if Congress reaffirms its support for employer- sponsored coverage and permits employers to have flexibility and continuity in offering valued health coverage to their employees and families.

Because of the strategic use of health care in the workplace, any health care reform legislation must support employer flexibility and innovative strategies and preserve the favorable tax treatment of employer- sponsored coverage. Allowing employers to determine the best health plan model for their organization, based on the needs of their workforce and the organization, is critically important to ensure employee satisfaction and reduce health care spending. If the tax treatment of these benefits is changed, it will negatively impact millions of Americans and their families.

Taxes and burdensome regulations will result in increased out-of-pocket costs for employees, limit employer innovation in health offerings and will ultimately lead to the erosion of the employer-sponsored health care system.

For example, one of the tax policies within the Affordable Care Act (ACA) that is already having an adverse effect on both employers and employees is the anticipated 40 percent excise tax ("Cadillac tax") on high-value, employer-sponsored health care benefits. The impending tax was initially intended to target excessively generous health plans and applies to benefits exceeding certain thresholds ($10,200 for individual coverage and $27,500 for family coverage). However, it is impacting more modest plans, which will negatively impact employees through increased costs, higher copays and deductibles and could even cause some to decline employer-provided health care.

Although the ACA's excise tax is not scheduled to go into effect until January 2020, HR professionals and their organizations have already begun restructuring their health care benefit offerings or increasing workers' deductibles and copays to avoid the tax.

SHRM strongly supports and encourages Congress to fully repeal the excise tax.

One strategy Congress should consider to reduce health care costs and preserve American's access to medical care is medical liability reform. SHRM supports the Help Efficient, Accessible, Low-cost, Timely Healthcare "HEALTH" Act (HR 4771). The HELP Act would strike a balance between protecting patients harmed by medical malpractice and prevent unnecessary and costly litigation that contributes to rising health care costs.

In closing, as you continue to evaluate health care reform proposals, I urge you to preserve the tax treatment of employer-sponsored health benefits. SHRM looks forward to working with you and your colleagues to continue supporting and strengthening employer-provided health care coverage. If you have any questions please do not hesitate to contact me at Mike.Aitken@shrm.org or by telephone at (703) 535-6027.

Sincerely,

Michael P. Aitken
Vice President, Government Affairs

CC: The Honorable Paul Ryan
The Honorable Kevin McCarthy
The Honorable Steve Scalise
U.S. House of Representatives Committee on the Budget
U.S. House of Representatives Committee on Energy and Commerce
U.S. House of Representatives Committee on Education and the Workforce
U.S. House of Representatives Committee on Ways and Means

ERIC The ERISA Industry Committee

The Only National Association Advocating Solely for the Employee Benefit and Compensation Interests of America's Largest Employers

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Statement by The ERISA Industry Committee for the April 14, 2016 Hearing on "Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce" before the Subcommittee on Health, Employment, Labor and Pensions of the Education and the Workforce Committee

Chairman Kline, Ranking Member Scott, Subcommittee Chairman Roe, Subcommittee Ranking Member Polis, and members of the Committee and Subcommittee, thank you for this opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC). ERIC is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor retirement, health, and compensation benefits for millions of workers, retirees, and their families. ERIC's members provide comprehensive health and retirement benefits to millions of active and retired workers and their families. Preserving and enhancing the employer-sponsored health and retirement systems and the tax incentives that support them are key policy goals of ERIC and its members.

ERIC welcomes the opportunity to comment on the many strong attributes of our national system of medical care, where the private health plans sponsored by employers provide the high-quality, affordable health care on which 175 million Americans rely.

Beyond providing the foundation on which the American health system rests, employer-sponsored plans also drive the engine for medical innovation, which in turn leads to higher quality, more efficient health care. In addition to pursuing ground-breaking efforts with respect to payment and delivery system reforms, employers have improved the health of American workers through pioneering wellness programs, which often are available to the families of workers as well as the workers themselves. Employers have taken great pains and often incurred considerable expense to develop wellness programs that appropriately encourage workers to take charge of their health and provide the tools necessary to achieve their individual goals.

Employers also have instituted significant advances in bringing health care to where workers and their families live and work, focusing their attention on eliminating time and location as factors that can impede the delivery of health care. For instance, many employers have built and expanded onsite medical clinics so that their employees can access medical services easily and conveniently, often enabling them to obtain treatment early on so that small medical issues do not turn into more dangerous conditions.

Many employers have also introduced telehealth services to their workers not only to increase ease of access for young and old alike but also to make specialized medical care available to workers and their families in regions where such care would otherwise be difficult to obtain or virtually unavailable. Employers have been at the forefront of this effort to expand telehealth and have considerably outpaced any governmental efforts to do so.

In addition to this innovative role, employer-sponsored health plans also embrace another key feature: their plans are tailored to the needs and attributes of their workforces. Thus, employers with an aging workforce with many chronic conditions can structure both their health plans and their wellness programs to focus on these conditions, whereas a tech employer with younger employees might focus on issues of more immediate concern to this age group. The bottom line is that a one-size health plan does not fit all workforces, and employer-sponsored health plans have achieved considerable success in tailoring benefits for their own unique group of health plan participants.

Employer-sponsored group health plans play an essential, irreplaceable role in the American health care system. They offer high-quality, efficient medical care to 175 million people, the vast majority of whom like their health plans and want to keep them. We all must take care to encourage employers to continue not only their important work as plan sponsors but also their key role as medical innovators and not to take steps that would discourage plans from taking on these considerable financial and administrative challenges that benefit us all.

Thank you for this opportunity to submit testimony on this important issue. ERIC stands ready to work with Congress to enact legislative changes that will strengthen the employer-sponsored system and improve health coverage for all Americans. If ERIC can be of further assistance, please do not hesitate to contact James Gelfand, Senior Vice President for Health Policy, at jgelfand@eric.org or (202) 789-1400.

Christine Scullion
Director,
Human Resources Policy

April 15, 2016

United States House of Representatives
Committee on Education and Workforce
2176 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Kline and Ranking Member Scott:

The National Association of Manufacturers (NAM) is pleased to provide this statement for the record with the goal of promoting continued innovation and improvements to the employer-sponsored system which covers half of all Americans.

The NAM is the nation's largest industrial trade association and the voice of 12 million men and women who make things in America. The NAM is the leading advocate for a policy agenda that helps manufacturers compete in the global economy and create jobs across the United States.

Manufacturers have long been committed to improving the quality of life of the workforce and their families. They recognize that providing health care coverage is an essential component of remaining competitive by attracting talent and maintaining a healthy, stable workforce. Manufacturers continue to seek flexible health care options to reduce costs and preserve a commitment to their workforce.

Employers are continuously implementing innovative ways to control costs and provide higher quality coverage to their employees such as employer-sponsored wellness programs, private exchanges, on-site clinics, and other creative benefit strategies aimed at improving access to affordable care. Any adverse change to the current health care system that limits employer options will create disruptions that threaten these innovations and the health care currently provided to 175 million American employees.

Manufacturers believe providing incentives that encourage employees to engage in healthy behaviors and preventative activities can improve outcomes and lower health care costs, and should be encouraged, not discouraged. We urge Congress to develop responsible reforms that address persistent challenges in the delivery of health care and advance innovation without further government interference.

Thank you for the opportunity to comment.

Sincerely,

Christine Scullion

CLS/jmm

Hallmark Cards

April 21, 2016

The Honorable Phil Roe
Chairman
Subcommittee on Health, Employment
Labor and Pensions
U.S House of Representatives
Washington, D.C. 20515

Dear Chairman Roe:

Thank you again for the opportunity to testify at the recent hearing on employer innovations in health benefits. It was my privilege to testify on behalf of the American Benefits Council.

I want to take this opportunity to provide further information for the official hearing record in response to a question from Congressman Grothman regarding the cost of health coverage for Hallmark employees. There is not a single answer to the question because what an employee pays varies greatly depending on a number of factors: which insurance carrier the employee selects, which plan offered by that carrier is chosen, what type of coverage (e.g. employee-only or family), and in which part of the country the employee resides. To expand more fully on these factors:

- Employer Defined Contribution. With the AON Exchange, Hallmark provides its employees a range of options (Bronze, Silver, Gold) offered through a variety of carriers (three national carriers and several regional carriers). Hallmark provides the same level of funding whether the employee chooses the least expensive (Bronze) or the most comprehensive (Gold) benefit.
- Geographic Pricing. Premiums also vary across the country based on the rates established by the carriers. In any one geographic area, employees have a choice of plans (and separate premium rates) from each carrier for each plan. For example, for Bronze coverage alone, the employee would choose from the Bronze premiums from the three national carriers.
- Choice results in wide array of Employee Premium Levels. There is great variance between how much the employee pays—based on their selection of the plan that best meets their needs. For example, for employee-only coverage, the lowest cost Bronze plan in one region is $10 per month while the most expensive Gold plan is $210 per month in another region. There are also very wide variances for employee and spouse, employee and children and employee and family coverages.

Congressman Grothman correctly noted the significant cost savings that can result from telemedicine and onsite care. This further underscores a separate point in my testimony about the importance of repealing the so-called "Cadillac tax" provision of the Affordable Care Act. Since such costs are factored-in to determining whether a plan will trigger the tax, these valuable services that contribute to better health outcomes and ultimate cost savings will be greatly discouraged unless the tax is repealed.

Thank you for the opportunity to expand upon these matters for the official hearing record.

Sincerely,

Tresia Franklin /bb

Tresia Franklin
Director, Rewards & Employee Relations
2501 McGee, PO Box 419580, Kansas City, Missouri 64141 (816) 274-5111

Statement by the National Association of Worksite Health Centers to the Subcommittee on Health, Employment, Labor and Pensions of the Education and the Workforce Committee regarding its hearing on "Innovations in Health Care: Exploring Free-Market Solutions for a Health Workforce"

April 26, 2016

On behalf of the National Association of Worksite Health Center (NAWHC), I'm pleased to submit to you information related to how employer onsite and near-site health and wellness centers are a disruptive force for improving the health and reducing the cost of care for covered populations throughout our nation.

The Chicago-based, NAWHC (www.worksitehealth.org) is the nation's only non-profit association supporting employer-sponsors of onsite, near-site, mobile health, pharmacy, fitness and wellness centers. It assists employers in exploring this benefit strategy and in developing and expanding the capabilities of onsite centers to integrate all worksite primary, acute, behavioral health, occupational health and chronic care services and wellness programs.

We conduct educational programs, networking and benchmarking activities, while serving as an advocate for the employer-sponsors of worksite health centers. NAWHC also provides online resource materials on worksite health and fitness centers, on-site pharmacies and wellness centers at www.worksitehealth.org.

Overview of Worksite Health Activities

It's important for the Committee to understand that even before the ACA was passed, employers of all sizes offered a broad array of services to workers:

- Treatment of injuries
- Occupational health
- Identification of risks
- Prevention of illness
- Health education
- Chronic disease management
- Wellness programs
- Primary care
- Health coaching
- Ancillary services, such as pharmacy, lab, therapy, dental and other services

Since the 1930's, employers, especially manufactures, began providing first aid or occupational health clinics to address worksite injuries and accidents. These have now evolved to address the high cost, fragmentation and limited resources of various communities health care systems, as well as the needs of covered populations.

The Value and Prevalence of Employer Health Clinics

Employers have found that an onsite center offers a vehicle to integrate, enhance and increase the coordination of care and the engagement of workers in employer-sponsored health-related services and programs.

Today, around 30% of public and private employers offer some form of onsite, near-site or mobile health services to employees, dependents, retirees and others. While many vendors recommend at least 1000-1500 employees in a single location to support center, many employer-sponsors of centers have smaller populations. Centers range from one day a week operations, led by Nurse Practitioner or Physician Assistant, to 5-7 day a week centers, open evenings and weekends, primarily staffed by physicians.

Worksite health centers are not limited to large employers or manufacturers or those in rural locations. We find employers as small as 100 workers, in all industries and communities ,have found value in offering onsite care.

Employers find onsite or near-site clinics help them and their workforces deal with a variety of key problems and challenges, including access to care, having to leave work for extended time to get care or services, lower productivity, high out of pocket costs for community providers, high use of emergency rooms for non-emergency conditions and lack of time to address health problems.

While many employers who have clinics locate them onsite, an increasing number use near-site clinics, mobile vans, telemedicine or even physician visits to the worksite to provide easily accessible services. Over 60% offer services at no or minimal cost to employees.

Regardless of the model used, employers find these clinics meet their financial, health and wellness objectives, lowering the need for outside high cost services, increasing the health of the workforce, enhancing productivity levels, reducing absenteeism, all while providing a benefit that is highly regarded by employees.

nawhc
NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

Onsite Clinics and the Excise Tax

As we look at the ACA and its relationship and impact of employers, it seems clear to us that that the law seeks to achieve the Triple Aim of reducing costs, improving patient experiences and improving the health of populations. Employer onsite clinics were developed and are successful in achieving these same objectives.

We are concerned that the ACA's excise tax provisions, which were intended to reduce costs in the health care system by having employers reduce or eliminate high cost- Cadillac-benefits, will impede further proliferation of onsite care. Clinics accomplish reduction of costs by offering workers improved access to convenient no or low cost services, reducing the need for expensive emergency room care for non-emergency conditions.

We believe that employers who sponsor clinics should be incentivized to expand and offer more clinics, not penalized under the ACA's excise tax which includes a clinic's cost in establishing the level of taxation applied to an employer's benefits. This will discourage their growth and use.

I would be pleased to provide additional information or insight into any of the above background on the positive contributions of onsite and near-site health and wellness centers, either via email, on the phone or in person.

Thank you for your consideration of our perspectives.

Sincerely.

Larry S. Boress
Executive Director

Statement
of the
U.S. Chamber
of Commerce

ON: ***"Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce"***

TO: ***THE HOUSE EDUCATION AND THE WORKFORCE COMMITTEE'S SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS***

DATE: ***April 28, 2016***

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations. The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system.

More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large.

Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented. The Chamber has membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides opportunities, not threats. In addition to the American Chambers of Commerce abroad, an increasing number of our members engage in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Statement on
"Innovations in Health Care:
Exploring Free-Market Solutions for a Healthy Workforce"
Submitted to
THE HOUSE EDUCATION AND THE WORKFORCE COMMITTEE'S
SUBCOMMITTEE ON
HEALTH, EMPLOYMENT, LABOR, AND PENSIONS
on behalf of the
U.S. CHAMBER OF COMMERCE
April 14, 2016

The U.S. Chamber of Commerce, the world's largest business federation representing the interests of more than three million businesses and organizations of every size, sector, and region, appreciates this opportunity to provide a statement for the record as part of the House Education and the Workforce Committee's Subcommittee on Health, Employment, Labor, and Pensions April 14, 2016, hearing titled "Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce." The Chamber and its members continue to strongly support employer-sponsored health care coverage and the innovations it produces throughout the health care system. We have summarized our views, and the views of the employer community, below for the record.

The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system. More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large. Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented.

The Chamber and its members have long championed the invaluable benefits that the employer-sponsored health care system provides to both employees and employers alike. As Subcommittee Chairman Roe and Subcommittee Ranking Member Polis noted in their opening statements, more than 175 million Americans currently rely on health insurance through employer-sponsored plans, making it the most popular form of insurance today. Most importantly, the employer-sponsored system allows employers to customize the benefits offered to best serve the needs of their workforce and manage cost growth in health care.

Employer-sponsored health coverage has always been an important component of employee compensation and is also critical for businesses to attract and retain employees. The private sector has played an essential role in benefit developments that are improving health, reducing unnecessary costs and rewarding high value care throughout the health care system. Employers have crafted workplace wellness programs, disease management and care coordination initiatives, value-based insurance incentives, and health information technology resources to improve the health of their employees.

As the witnesses demonstrated, employers have driven recent advancements in health care coverage through the adoption of workplace wellness programs, the implementation of private exchanges, use of the Accountable Care Organization (ACO) model, and the integration of telemedicine into plans. However, providing affordable health insurance coverage is becoming progressively more challenging with new restrictions on plan design and new requirements governing employer-sponsored coverage.

For example, despite being incentivized under the Affordable Care Act (ACA), employer wellness programs are currently in a state of limbo. Employers whose programs are compliant with the Health Insurance Portability and Accountability Act (HIPAA) and the ACA cannot be sure that they will not be sued by the Equal Employment Opportunity Commission (EEOC). In 2014, EEOC filed several high profile cases against employers that alleged that the employers' wellness programs were not voluntary under the Americans with Disabilities Act (ADA). Since then, the EEOC has released proposed rules seeking to incorporate a variety of new restrictions on workplace wellness programs. Onerous regulations like these will deter employers from being able to innovate and offer workplace wellness programs best suited to their employees' needs.

Any forthcoming health care reforms must take into consideration the vital role of the employer-sponsored system in facilitating the innovation and creativity that is happening in the private sector offering of health care coverage. As the foundation of our health care system, we support flexibility for our nation's employers as they continue their commitment to providing innovative, sustainable and high-value care for all Americans.

The Chamber thanks you for taking the time to hold this important hearing on the importance of encouraging innovations in health care and how employers continue to support a healthy workforce. We look forward to working with you as you continue to examine this important issue. Please do not hesitate to contact us if we may be of assistance in this matter.

Education and the Workforce Committee
Subcommittee on Health, Employment, Labor and Pensions
"Innovations in Health Care: Exploring Free market Solutions for a Healthy Workforce"

Statement for the Record
Heidi B. Capozzi
Senior Vice President, Human Resources
The Boeing Company

Chairman Roe, Ranking Member Polis, and distinguished members of the Committee, thank you for the opportunity to submit for the record a description of Boeing Company's pioneering health care innovations. This Committee has a storied history of overseeing, informing, and, most importantly, leading on issues relevant to the enhancement and preservation of the employer-sponsored insurance system.

First, I would like to provide a brief overview of the Boeing Company. The Boeing Company is the world's largest aerospace company, the largest U.S. manufacturing exporter and leading manufacturer of commercial jetliners and defense, space and security systems. With our corporate headquarters in Chicago, Illinois, Boeing has over 152,000 employees in the U.S. In 2015, Boeing paid nearly $50 billion to approximately 15,000 businesses, supporting an additional 1.5 million supplier-related jobs across the country. Our business contributes nearly $1 billion into the U.S. economy each week.

In addition to contributing to our nation's economy, Boeing believes in immersing ourselves into our communities. The company's Global Corporate Citizenship program distributed over $127 million to charitable organizations last year. Through the generosity of our employees, an additional $41 million in charitable contributions was distributed to organizations that address needs such as education gaps, veterans' services, and homelessness.

Given our large footprint and operations, it's natural for our company to focus on health care benefits for our employees. These benefits are critical to Boeing's mission and workforce. Our health plans contribute directly to the productivity and morale of our employees. These benefits are critical to meeting our business goals and contribute to fewer missed days, higher quality work, and a healthy and positive environment. The company faces global challenges and competition for a highly skilled and specialized workforce. Tailoring benefits to our workforce supports our recruitment and retention of the labor force we need to compete globally.

The company provides high quality, affordable, efficient and competitive health coverage to over 500,000 people including our employees, dependents, and retirees. This coverage spans 48 states, multiple populations, and includes unique plan innovations. We take an active role in partnering with vendors, associations, and the provider community to create ground breaking improvements to health care delivery,

ranging from wellness programs to accountable care organizations (ACOs). Boeing is one of a few national employers that negotiate directly with hospitals and medical groups to provide the highest quality and lowest cost coverage possible.

The Importance of Innovating

The amount of money that Boeing spends annually on health care is significant—over $2.6 billion. There are constant efforts to reduce the cost while maintaining the goals for productivity and the goals of our workforce. Making the health care delivery system more efficient and more user-accessible not only pays dividends to our employees, but it also results in critical cost savings to the company.

Our health care work and innovations also provides a benefit to the communities where we have a presence. Pushing providers in the right direction—away from fee for service and towards paying for outcomes—improves the health care system for us and for the entire area, including for small and mid-sized businesses.

Boeing's Intensive Outpatient Care Program

The Intensive Outpatient Care Program, or IOCP, was Boeing's first major health innovation. It began in 2006 and was a flagship, direct contract, program that provided a new delivery method for our most chronically ill employees. Like with Medicare and Medicaid, the most expensive 5-20% of our employee population accounts for up to 80% of the total costs. The IOCP focused on this population and provided a high level of personal engagement to help them navigate the often complicated health care system. For example, under our self-insured plans we provided a dedicated nurse care manager and access to 24/7 care, including home visits in order to deliver proactive, continuous, and specialized care.

The IOCP demonstrated net savings of 20% within this population, primarily attributable to reduced emergency room visits, hospital admissions and stays. The program also demonstrated significant productivity gains with participants taking less than half the number of sick days they did prior to the program. Employees rated themselves as being far more productive while at work. The program not only saves money and increases productivity but has also resulted in significantly improved health outcomes for participants, with hypertension rates 30% better than the national average and significantly improved self-assessment of emotional, mental, and physical wellbeing. The program has been underway in the greater Seattle and St. Louis regions and is being modeled within Medicare through a $26 million grant from the Centers for Medicare and Medicaid Innovation.

This medical home model was in some ways a predecessor to the next major innovation at Boeing—the Preferred Partnership model. The IOCP provided the data and experience necessary to expand our direct contract work into something larger that could benefit all our employees, not just our chronically ill.

Boeing's Preferred Partnership Model

Boeing rolled out the Preferred Partnership model at the beginning of 2015 in the Puget Sound area and in the St. Louis and Charleston areas at the beginning of this year. The model is based on the concept of an accountable care organization ("ACO") aligning incentives between the provider system and Boeing, securing discounts from hospitals in exchange for patient volume of Boeing participants. The company negotiated directly with health care systems in the three locations previously mentioned—Puget Sound, St. Louis, and Charleston. By incentivizing employees to stay within a particular hospital system's network, the hospital can ensure high quality standards and continuity of care, subsequently removing wasteful spending. The savings realized through reduced waste are then shared with Boeing and passed along to our employees through lower employee cost-sharing.

The choice of the Preferred Partnership option is offered on top of the current plan offerings available to employees during annual enrollment. In Puget Sound, WA, for example, employees can keep the same plan they have historically had with the same broad network, or they can select the Preferred Partnership option, which comes with improved quality of care, better patient experiences and a network specific to our ACO partner. The ACO partner's network becomes the in-network benefit for any given plan.

Incentives to select the Preferred Partnership option include:

1. Free primary care office visits (subject to the deductible for our High-Deductible Plan);
2. Free generic drugs (subject to the deductible for our High-Deductible Plan);
3. Lower paycheck contributions; and
4. Higher company contributions to the Health Savings Account (if the High-Deductible Plan with the Preferred Partnership option is selected).

Our ACO partners also provide additional resources, such as dedicated call centers and websites that can be used for appointment scheduling, and triage. These partners are investing in technologies to improve electronic medical records, coordinate care for our sickest population, and ensure quick access to primary care providers and specialists. In effect, employees within the Preferred Partnership option receive "concierge care" as they have quicker response times and better tracked care than they would have otherwise.

What makes the Boeing model particularly unique is that it is a direct contract ACO that has both upside savings and downside risk, both attached to quality outcomes. By having both upside savings and downside risk, we have aligned incentives with the overall health care system. The providers are motivated to seek out opportunities to improve efficiency because they have a direct financial stake in the outcome. The hospitals we contract with benefit from savings to the system if wasteful procedures are eliminated. For example, one metric in our contract measures the prescription rate of

generic drugs when they are available. Prescribing generics saves both Boeing and the hospital system money and we share those savings. However, if the system does not meet the goals set forth in our negotiated contract, a penalty is paid to the plan. This is called shared risk and is a strong incentive to focus on outcomes rather than "fee for service". Doing this drives efficient behavior while also improving health for our employees. Similar to our continued efforts within our businesses, removing waste from the health care system is one of our primary goals. This shared risk is a strong incentive to focus and reward outcomes instead of volume, which is essentially how fee for service medicine works.

While the specifics of all our outcome measures are proprietary, some examples include the following:

1. The system must provide timely access and response to our employees;
2. Members of the Preferred Partnership must receive appropriate cancer screenings; and
3. Members with diabetes and hypertension must receive certain tests and be appropriately tracked.

These metrics are endorsed by the National Quality Forum and by specialty physician groups. If the system meets their financial goals and the quality metrics, they are eligible to receive a share of the program savings.

The results of the ACO are successful. Early indicators suggest strong results from a quality and member experience perspective. An early analysis of the metrics suggests improvements over our non-ACO population, particularly regarding steps for cancer and diabetes prevention. Based on focus group results, employees are happy with the program, giving it an average rating of 8.5 out of 10. Providers have been eager to test the model and have willingly participated.

We are proud of these early accomplishments and welcome questions about our program. Our plans to expand the Preferred Partnership option and continue forward with value-based payments will continue. It's what is right for our employees, our company, and the country.

Challenges to Innovations

Boeing plans to continue forward with efforts to reduce the cost of care while ensuring high quality, affordable and competitive coverage to our labor force. That said, there are policy barriers that make this task difficult.

Two main policy themes consistently provide challenges or risk to our efforts. The first is the implementation of the Affordable Care Act (ACA) and the second is the tax treatment of health care benefits.

While we support the long-term goals of health reform, the ACA has added (and continues to add) significant additional costs to Boeing since its inception in 2010 and

that is a business challenge for us. New costs include fees, such as the transitional reinsurance program fee, to help support the implementation of health insurance marketplaces, even though very few, if any, Boeing employees are likely to enroll in coverage in the marketplaces. The ACA coverage mandates alone cost the company roughly $260 million over five years. The high cost of compliance and implementation adds a significant burden resulting from this very complicated and evolving law.

These mandates, taxes, and fees add to our internal company costs, but these cost could be reduced by mitigating the burden of the ACA on companies like ours.

In that vein, the existing and proposed changes to the tax treatment of health care benefits presents us with enormous challenges. For instance, the ACA's 40 percent excise tax (also known as the "Cadillac tax") on high-cost health plans will increase costs for our employees, retirees, and the company. Opposition to this tax is nearly unanimous. Business, labor, and consumer groups alike have expressed serious concern about its impact on workers and their families, and the U.S. Senate voted 90-10 in favor of repeal. It is important to note that included in the calculation to determine what is considered "excessive" (and subject to the 40 percent excise tax), are many of the new coverage mandates under the ACA, which is particularly discouraging when the purpose of this excise tax was to discourage employers from offering "excessive" benefits. In our view, mandated coverage should not be included in the determination of what is excessive for purposes of determining this excise tax. Further, this tax will not reduce health care costs or increase wages for our employees and their families. We support the repeal of this misguided excise tax.

Proposed changes to the current exclusion from taxation of health benefits for employees would face the similar opposition and contain the same policy flaws as the Cadillac tax. For example, an arbitrary cap on the tax exclusion would have the effect of penalizing older and sicker workers, women, and large families. It would also unfairly penalize employees in high cost health care areas. The Boeing Company is currently able to absorb these price shocks for our employees, but if subject to the Cadillac tax or with changes to the tax exclusion we would no longer be able to do so. The result would be disparate treatment of our populations and ultimately morale and productivity would suffer.

Given what is at stake for our employees, retirees, and their families, it is critical that policymakers and regulators get this right. We are open to modifications and continue to support delivery and payment system reform that increases the quality and efficiency of health care, but not at the expense of the wellbeing of our employees.

As Congress examines options to address the employer-sponsored health insurance system, we urge you to consider the true value of the tax treatment of benefits and the weight of the current mandates. Removing costly mandates and preserving current tax benefits allow employers to freely negotiate on behalf of employees. This would promote higher quality, more efficient coverage by leveraging competition in the health care industry.

The Boeing Company is putting great effort into transforming the employer-sponsored health care system through creative innovations. We believe our approach is a good example of how a private sector employer is using the free market to change the delivery system, which will not only make our employees healthier, but make the system more cost effective overall.

[Whereupon, at 12:15 p.m., the Subcommittee was adjourned.]

○