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EMPLOYER WELLNESS PROGRAMS: BETTER HEALTH OUTCOMES AND LOWER COSTS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING EMPLOYER WELLNESS PROGRAMS, FOCUSING ON BETTER HEALTH OUTCOMES AND LOWER COSTS

JANUARY 29, 2015

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C O N T E N T S

STATEMENTS

THURSDAY, JANUARY 29, 2015

EMPLOYER WELLNESS PROGRAMS: BETTER HEALTH OUTCOMES AND LOWER COSTS

THURSDAY, JANUARY 29, 2015

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room 430, Dirksen Senate Office Building, Hon. Lamar Alexander, chairman of the committee, presiding.

Present: Senators Alexander, Burr, Isakson, Scott, Murray, Mikulski, Casey, Franken, Bennet, Baldwin, and Murphy.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

This morning our hearing is Employer Wellness Programs: Better Health Outcomes and Lower Costs.

Senator Murray and I will each have an opening statement. Then we'll introduce our panel of witnesses. We have your statements, and we'll ask you if you could summarize your comments in no more than 5 minutes. That will leave us more time for questions and interaction.

The Senate is voting today, and voting is to begin at 11, which means we'll probably conclude the hearing about 11:15 or 11:20. We'll stay as long as we can, have as many questions as we can, and if there are any additional questions by Senators or if things come up that you would like to say to us, please submit them after the hearing is over.

If we're going to have a conversation in our country about enabling high-quality, low-cost insurance, we probably should start with the roughly half of Americans who have health insurance through an employer. That's 159 million Americans, more than the 54 million Americans in Medicare, and more than the 69 million Americans in Medicaid and the Children's Health Insurance Program.

Today we're going to hear from employers who are helping employees lower their insurance costs through employer wellness programs. There's a lot of support for this idea. Senator Murray and I were with Secretary Burwell yesterday morning, and she was talking about her announcement Monday that signals a willingness to work with employers to reform the way that we provide health care to workers, which includes wellness programs.

In a similar vein, wellness programs are turning the table on the health care system, making it more oriented toward the individual, and helping people be healthy instead of curing them when they're sick.

I hope we can learn three things today: how well are the programs working; are the regulations that the government has regarding wellness programs working or do they need to be improved; and is the General Counsel of the Equal Employment Opportunity Commission discouraging something that promises to lower Americans' health care costs?

Now, it's no secret Obamacare was not a bipartisan law, but it did include a bipartisan provision to strengthen workplace wellness programs. Senator Harkin, Senator Murray and I and many Republicans worked together during the HELP Committee markup of the Affordable Care Act. Before the Affordable Care Act, employers relied on a 2006 regulation that empowered them to discount employee premiums up to 20 percent for making healthy lifestyle choices.

Today, employers have the certainty of law that they can offer their employees up to 30 percent off their premiums for doing things like maintaining a healthy way of keeping their cholesterol levels in check. The law also gives the Secretaries of Labor and Health the authority to extend this discount to 50 percent through regulations, and the Secretaries have done just that for tobacco cessation.

But these discount programs aren't a blank check. Under the Affordable Care Act, employers have to meet several conditions. They can't discriminate. These programs have to be available to everyone. There have to be reasonable alternatives if the employee can't complete the program's standard requirement. They have to be designed to promote health. You can't offer a reward for better job performance, but you can for stopping smoking. And third, you have to be able to qualify at least once a year.

To get started, employees might fill out a questionnaire about themselves and their family's medical history. Then they would work with a medical professional to improve on that. That information could only be provided to employers in the aggregate under Federal privacy laws.

Employers seem to think these programs work. They're rapidly adopting them. A September survey last year showed that 18 percent of employers already use outcomes-based wellness incentives; 48 percent plan to add one by 2017. Some of the witnesses today will tell us that well-designed plans can be very effective. Are they working as well as they can? Do you have all the tools you need? And what about the EEOC's attitude? Is that a problem or is it not a problem?

Recently, the EEOC General Counsel sought an injunction against Honeywell which seemed to make the argument that any sort of premium discount the company offered to its employees for participation in the company wellness program made that participation involuntary.

We had a lot of discussion here in the committee on the Affordable Care Act about the importance of allowing companies to provide premium discounts in exchange for wellness programs, and we

want to make sure we don't have a countervailing move going on in the government to discourage that. Even the White House has expressed concern regarding the EEOC's actions. When asked what the President thought about the EEOC wellness lawsuits, the White House Press Secretary said the Administration is concerned because these lawsuits could be "inconsistent about what we know about wellness programs and the fact that we know that wellness programs are good for both employers and employees."

Congress was clear in the health care law. The Administration was clear in its regulations. The White House has reiterated its support. Employers are adopting these programs. We don't need confusion. And if confusion persists between different government agencies, I will work on legislation to provide clarity.

But hopefully there's a lot of good news in today's testimony about what employers are doing to make health insurance less expensive for employees in exchange for employees leading a healthy lifestyle.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you very much, Chairman Alexander. And thank you to our colleagues, and especially to our witnesses, for being here today.

I'm especially glad to have a Washington State constituent here today to testify, Dr. David Grossman of Group Health in Seattle. Thank you for making the trip across the country.

I'm really looking forward to this conversation today not only because this is such an important topic but because I'm hoping this kind of hearing on Affordable Care Act initiatives could help us refocus the debate on what really matters, and that is making our health care system work better for the families and communities that we serve. To me, this means fighting for more affordability, accessibility and quality, for a health system that works for women, families and seniors and puts their needs first.

The Affordable Care Act was an historic step toward that goal. It has helped millions of people get more affordable, quality health care coverage, it has allowed young people across the country to stay covered, and it has put the power back in the hands of the patients, not the insurance companies.

It is also encouraging new, innovative delivery systems that have helped drive down the cost for patients, and there's certainly more we need to do.

So I'm really glad that our Republican colleagues have joined Democrats in a conversation about how employer wellness programs can help improve our health care system and build on the progress that we have made so far.

One important focus of the Affordable Care Act is to help people stay healthy and identify serious health risks sooner through preventive care. It has been exciting to see businesses nationwide respond to incentives included in the law by creating workplace wellness programs to help workers and families stay healthy, improve the quality of care, and reduce health care costs.

I'm very impressed, for example, with the results that Dr. Grossman will discuss today. In 2010, Group Health partnered with King

County in my home State of Washington to offer an alternative lower-cost health care plan. The plan focused on preventing health problems rather than responding to them after the fact. They've seen some great progress so far, fewer claims for emergency rooms or hospital visits, lower out-of-pocket costs for employees, and very high ratings for quality of care.

Our other witnesses will also be able to discuss the ways workplace wellness programs and new, innovative approaches to care can make a real difference for workers and their families. As we know, workers are putting more and more hours in on the job, and that makes it all too easy for some of the habits that help us stay healthy, like making an appointment for a checkup or getting some exercise, to fall through the cracks. So I really do appreciate businesses that are helping their employees prioritize their health.

But I think all of my colleagues and the witnesses here today would agree it is critical these programs reflect the highest standards of workplace equality and fairness. Workplace wellness programs should be a tool to help all workers improve their health, to strengthen quality of care, and to drive down costs for patients and businesses alike. They should help workers, not discriminate against people with disabilities or harshly penalize employees who do not take part in wellness activities to boost their bottom line.

I'm very concerned about some of the stories I've heard about workers being pressured to share personal health information, or losing coverage as a result of companies taking a wrong approach, and that, of course, is completely unacceptable. I want to make sure that wellness programs can continue to grow as a tool to help employees and not as a tool for discrimination.

So I'm really glad that we have Jennifer Mathis of Bazelon Center here today to talk about why it's important businesses uphold those protections. So, Jennifer, thank you for being here. I really actually appreciate you taking time on such short notice to come with us, especially as you have a brand new baby at home.

I am looking forward to hearing from our other witnesses from Dow Chemical and Caesars Entertainment about the programs they have implemented, as well as the amazing success that Chairman Alexander's constituent, Mr. Abernathy, has made.

And as I have said before, I am really hopeful that our Republican colleagues will really join Democrats and move together to improve our health care system, move it forward, not backward, for families across the country, and I hope today's hearing will really be an opportunity to move closer to that goal because I think we all know that finding ways to build on the successes many workers and businesses have seen so far with these wellness programs would be a really great start.

So, Mr. Chairman, I do have three statements I'd like to enter into the record today. They are from the National Partnership for Women and Families, Families USA, and the Consortium for Citizens with Disabilities.

The CHAIRMAN. Thank you. They will be.

[The information referred to may be found in Additional Material.]

The CHAIRMAN. Would you like to introduce two witnesses?

Senator MURRAY. I do have two witnesses I'd like to introduce, Mr. Chairman.

I want to again welcome my witness from Washington State, Dr. David Grossman, who traveled here from Seattle, where he is both a practicing pediatrician and leader at Group Health, which is a national leader in delivery of better, more cost-efficient care that serves 600,000 patients in Washington State and Idaho.

Dr. Grossman, thank you for traveling and being with us today.

And again, I just want to thank Jennifer Mathis. She is the deputy legal director and director of programs at the Judge David L. Bazelon Center for Mental Health Law here in Washington, DC. Mrs. Mathis will share her expertise on why protections are vital to ensure that workers are not discriminated against and rights are protected in employer wellness programs. And again, I particularly want to thank her for being here with a brand new baby at home. She said she only got a few hours of sleep last night. Many of us can identify with that, so we appreciate you taking the time to be here today.

The CHAIRMAN. Thank you, Senator Murray.

I want to welcome Dr. Gary Loveman, president and CEO of Caesars, chairman of the Business Roundtable's Health and Retirement Committee. He'll be testifying on behalf of both. Dr. Loveman has a Ph.D. from MIT. He spent a decade at Harvard. More importantly, his family came from Tennessee, I've learned. So, we welcome him.

Dr. Baase, Cathy Baase, chief medical officer at Dow Chemical, heads up an impressive workplace health effort. She has authored many articles in peer-reviewed journals on workplace health protection. She'll be testifying on behalf of her company and the American Benefits Council.

Matt Abernathy is a native Tennessean who resides in Nashville. He's been working for Blue Cross Blue Shield since 2002 and has been steadily promoted. He's an active participant in his company's wellness program. He drove all the way here with his family from Nashville.

We're grateful to you for doing that.

And finally, Mr. Eric Dreiband, Partner at Jones Day law firm, previously General Counsel to the Equal Employment Opportunity Commission in the Administration of President George W. Bush, and was Deputy Administrator of the Wage and Hour Division at the U.S. Department of Labor. He has spoken extensively about civil rights law.

Again, I will say to the Senators who are here, we have votes starting at around 11, but hopefully we'll have time, if the witnesses will stick to a 5-minute rule in their comments and Senators will be succinct in their questions, we may all have time to ask a question of the witnesses.

So, we look forward to the hearing.

Dr. Loveman, let's start with you.

STATEMENT OF GARY W. LOVEMAN, Ph.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CAESARS ENTERTAINMENT CORPORATION, LAS VEGAS, NV

Mr. LOVEMAN. Thank you, Mr. Chairman and Ranking Member Murray. It's an honor to be here, and it is indeed, I think, a happy subject that we're covering today, wellness programs offered by private employers, where we have a very encouraging record and I think great promise to improve the health of millions of Americans.

My name is Gary Loveman. I'm the chairman, CEO, and president of Caesars Entertainment in Las Vegas. I'm testifying today on behalf of the Business Roundtable, an association of CEOs of major U.S. companies operating in every sector of the economy, where I serve as Chair of the Health and Retirement Committee. I appreciate the invitation to appear before you today to discuss the opportunities that wellness programs create to improve health outcomes and lower costs.

As the largest source of health care coverage for non-elderly Americans, employers are in a great position to help tens of millions of Americans better manage their own health. Indeed, the Business Roundtable companies provide insurance for more than 40 million U.S. beneficiaries.

This is my 13th year as CEO of Caesars Entertainment, and I have to tell you that the most unappealing day of my year for many years early on in my tenure was the day when my Human Resources director would come to discuss with me how we might allocate the cost of rising health care between our employees and the company. This process worked as follows. She would come in with a description of the trend rate of growth in health care costs that various experts had indicated we might experience. We would adjust those trends for the specifics of our populations and locations, and then we would have a debate about how much of that increase in cost would be borne by the folks who work for us and their family members versus how much the company would bear. And sadly, in most instances, the expected rate of increase in health care costs exceeded the rate of increase in growth of the company's underlying business.

Such an exercise, a truly zero-sum game, is not a very pleasant experience for anyone when you have to consider the consequences of these decisions for the folks that are our friends and colleagues, and it struck me that we had to find a new way to approach this problem. It was such an unappealing dynamic, there had to be a better way to do it, and what emerged from these discussions in my office and many others was this paradigm we now refer to as a wellness program, which suggests that instead of having a rather passive exercise where the company provides an insurance program and employees go off and use it as best they can, we needed a partnership.

So beginning in 2010, I started appearing in employee dining rooms of our facilities three shifts a day, 7 days a week around the country saying to folks we're now in this together. We're going to have to make better decisions. I'm going to have to count on you to do better, more informed things to take care of your health and your family's health, and you have to count on me to do a better job of supporting you in that effort.

And we launched in that context something called Wellness Rewards, which is indicative of the innovation taking place in private employer health care around the country. When you think about these programs, they have, in my view, three fundamental components. The first is information, a much higher degree of literacy available to employees as they begin to make these important health care decisions; a level of support to make it easier for them to make well-informed decisions and follow through on them in a timely way; and incentives, some concrete encouragement that says if you make this decision thoughtfully, something very favorable will happen for you and your family that might not otherwise happen if you were to make a less well-informed decision.

And on the other hand, we have the obligation to support our employees in this effort and make sure that their care is of a higher quality and more affordable. In Caesars' case, we've been able to sustain the same contribution rate, the same absolute dollar cost contribution rate for our employees now for 6 consecutive years, which for people, many of whom are hourly workers, is a tremendous benefit.

Wellness programs are ideally suited to address the emergent epidemic of chronic disease in this country, which exacts a terrible toll on people's lives that, as we all know, are among the most easily preventable and manageable of conditions. Given the opportunity to lessen or eliminate chronic disease, it certainly makes sense that these programs, including government-related programs like Medicaid and Medicare, begin to offer incentives for people to participate. It's why there was bipartisan support at the time that the Affordable Care Act was put in place and why the Business Roundtable has supported those elements, importantly.

Wellness programs provide the opportunity for employers to create value for employees by helping them access the information and support they need to get and to stay well. They're designed to empower our employees with information about their health, both diagnostic and with respect to the provision of care, to help them get the care services they need at the right time and with the right level of quality.

Companies involved in these programs offer a wide range of services, from health assessments and biometric screenings at the early stages of these exercises, to direct services to help reduce risk factors and monitor outcome attainments. Many of these programs, including our own, also offer tools that help workers better understand their health, and employers offer customized interventions, disease management programs, access to expert second opinions, and strategies for adopting lifestyle changes to reduce individual health risks.

Over the last 10 years at Caesars, we've been driven by what we described as a partnership for health with our employees, their spouses, and their dependents. The combination of screenings, incentives, independent cost estimation information, quality information, onsite care in our facilities, often offered 24 hours a day, 7 days a week, along with disease management programs, have helped our employees improve their health and wellness, get access to information about preventable care, and take better care of themselves when in need. I'll give you just two examples.

In our facility in Joliet, IL, after discussing symptoms that she was experiencing with one of our onsite nurses at our clinic, our employee was referred to an ophthalmologist. She had an early diagnosis of glaucoma, I'm sure a diagnosis that she would not have been able to avail herself of in the absence of this program, is now undergoing treatment and is in very good condition as a result.

Another example. In Atlantic City, we had an employee who had a systolic blood pressure reading of 250 when she came in for a biometric screening. Of course, she was immediately rushed to the emergency room. She underwent double bypass surgery and is alive and well and prospering today. I would argue that in the absence of the incentives to participate in this program and to undertake the biometric screening that led to this diagnosis, we would not have such a favorable result today.

The CHAIRMAN. Dr. Loveman, if you could wind up?

Mr. LOVEMAN. I will indeed.

Members of the Business Roundtable believe that employer wellness programs provide significant potential for employees and their families. We are encouraged by the bipartisan support of these programs in the Affordable Care Act and the continued bipartisan support for these programs in the committee.

Mr. Chairman, thank you again for the opportunity to discuss these programs and the opportunities they create for improved health in private employer cases and public employer cases as well.

I'll be happy to answer any questions when available. Thank you.

[The prepared statement of Dr. Loveman follows:]

PREPARED STATEMENT OF GARY W. LOVEMAN, PH.D.

SUMMARY

Wellness programs are ideally suited to address the emergent epidemic in chronic diseases, which exact a terrible toll on people's lives, but are among the most easily preventable and manageable of conditions.

There was bipartisan support for expanding opportunities for the providers of insurance—from Medicaid to private sector employers—to offer incentive-based wellness programs in the *Affordable Care Act* (ACA).

The ACA lays out specific requirements that employers must meet in order to offer incentive-based wellness programs.

Under the law, employers must:

- Offer a well-designed program;
- Ensure that privacy protections are in place;
- Limit the value of the incentives to be offered; and
- Offer a reasonable alternative to meet the incentives for those employees who cannot participate for medical reasons.

Employer-sponsored wellness programs represent a partnership between the employer and the employee.

In the old days, the annual process of computing exogenous health care costs led to a total bill that had to be split between the company and the employee. It was a zero-sum game. Wellness programs allow for improvements to both sides of the partnership.

Employer-sponsored wellness programs are an ensemble of information, support and incentives designed to help participants improve their health and receive greater value. In return for participation, employers provide better and more affordable care.

The members of Business Roundtable believe that employer wellness programs provide significant potential for employees and their families. Further, we believe that over the long term, potential health care savings may come from behavioral changes, in which individuals become personally engaged by taking actions to avoid preventable conditions and detect other conditions as early as possible.

We are encouraged by the bipartisan support for these programs in the *Affordable Care Act* and the continued bipartisan support for these programs within this committee.

Good morning, Chairman Alexander, Ranking Member Murray and members of the committee.

My name is Gary Loveman, and I am chairman, CEO and president of Caesars Entertainment. I am testifying today on behalf of Business Roundtable, an association of CEOs of major U.S. companies operating in every sector of the economy, where I serve as chair of the Health and Retirement Committee.

Business Roundtable CEO members lead companies with $7.2 trillion in annual revenues and nearly 16 million employees. Business Roundtable member companies comprise more than a quarter of the total market capitalization of U.S. stock markets and invest $190 billion annually in research and development (R&D)—equal to 70 percent of U.S. private R&D spending. Our companies pay more than $230 billion in dividends to shareholders and generate more than $470 billion in sales for small- and medium-sized businesses annually. Business Roundtable companies also make more than $3 billion a year in charitable contributions.

Thank you for inviting me to appear before you today to discuss the opportunities that employer wellness programs create to improve health outcomes and lower costs. As the largest source of health care coverage for non-elderly Americans, employers are in a great position to help tens of millions of Americans better manage their own health. Business Roundtable members alone provide health care coverage to close to 40 million.

This year, 2015, is my 13th year as CEO of Caesars Entertainment. When I began, the single most unappealing event of the year was a discussion with my human resource leader about the allocation of rising health care costs between the company and our employees. We were provided an estimate of trend health care cost increases, we modified it for the specifics of our population and then agonized about who would pay for it. Such a zero-sum, lose-lose exercise is no way to make progress. We recognized that we had to find a new model—a partnership between employees and the company to engage everyone in the process necessary to improve wellness and make more informed decisions about value when purchasing healthcare. In 2010, Wellness Rewards was launched, and it is indicative of the innovation in private employer health care that is sweeping across Business Roundtable companies and employers more broadly.

Employer-sponsored wellness programs are an ensemble of information, support and incentives designed to help participants improve their health and receive greater value. In return for participation, employers provide better and more affordable care. Wellness programs are ideally suited to address the emergent epidemic in chronic diseases, which exact a terrible toll on people's lives, but are among the most easily preventable and manageable of conditions.

Given the opportunity to lessen or eliminate chronic disease through wellness and prevention programs, it makes sense that the providers of health insurance—from Medicaid to private sector employers—should offer incentives for people to participate in these programs. That is why there was bipartisan support for expanding opportunities for employers to offer incentive-based wellness programs in the *Affordable Care Act* and why Business Roundtable also supports that provision in the law.

To continue to be successful, employer wellness programs must evolve from engagement to the encouragement of goal achievement. Programs must include and integrate diagnostics, actions and outcomes. To comply with the law, incentive-based wellness programs must offer well-designed programs so that employees can achieve the goals they set. Programs must offer reasonable alternatives for employees who cannot participate for medical reasons, and they must ensure that strong privacy protections are in place.

The focus on wellness underscores the evolution underway in the U.S. health care system. In the traditional health care system, patients engaged when they needed surgery, hospitalization or other forms of more invasive treatment. The more modern approach includes giving people the tools and information they need to understand their own health care needs. This approach, also, by its very nature of seeking to lessen the need for more invasive forms of care, is one of the most effective ways to control health care costs.

Employers are engaging with employees and their families as part of the ongoing efforts of companies to drive innovations in health care and in the delivery of benefits. Wellness programs are integrated with the full suite of corporate health and safety initiatives. From innovative health plan design to creating a corporate culture dedicated to healthy living—companies are dedicating themselves to improving the

health and well-being of what my fellow Business Roundtable CEOs and I almost always cite as our companies' greatest asset, our people.

Employers understand the importance of having a qualified, productive and engaged workforce. For example, at Caesars Entertainment, we emphasize the health of our 65,000 employees as part of our broader approach to employee engagement and customer loyalty. Our goal is to change from being a passive benefits program to an active partner between our company and our employees. We see wellness programs as a key component of that relationship.

Wellness programs provide the opportunity for employers to create value for employees by helping them access the information and support they need to get and stay well. The programs are designed to empower employees with information about their health and to help employees get the right health care services at the right time. Many companies offer a range of services from health assessments and biometric screenings to direct services to help reduce health risk factors. Many also offer tools that help workers better understand their health, and employers offer customized interventions, disease management programs and strategies for adopting lifestyle changes to reduce an individual's health risks.

Over the last 10 years, we at Caesars have been driven by our "handshake for health" with our employees, their spouses and dependents. With our wellness program at its core, we've provided a comprehensive suite of services to help employees manage their health.

Since 2010, our wellness program has focused on incentivizing our employees to get biometric screening, complete their annual physicals and engage onsite resources to manage their own health.

The potential in these programs is most evident in the stories from our employees:

• An employee in Joliet came to one of our WellNurses with questions and describing symptoms. The nurse recommended that she see an ophthalmologist as soon as possible. She did, and, as a result, received an official early diagnosis of glaucoma and is undergoing treatment.

• After a biometric screening, the wife of an employee in Ak-Chin discovered that her sugar level was over 500. The WellNurse reviewing the biometrics sent her immediately to a doctor. She is now effectively managing her diabetes and her husband credits the nurse with saving his wife's life.

• In Atlantic City, a WellNurse met an employee whose systolic blood pressure registered 250 at an onsite biometric screening event. The employee was sent to the emergency room where he immediately underwent double bypass surgery. Now back at work and feeling well, the employee credits the screening with saving his life.

The anchor of these programs is the independently operated onsite clinics and health coaches that can help employees reach their goals. We currently offer five full-service clinics, six mini-clinics and 28 health coaches across the country.

While these integrated solutions are critical in helping improve health outcomes and lower costs, we also couple them with tools to help employees have the information they need to make informed health care decisions. This consumer-centric approach includes a health care cost transparency tool, where our employees have already performed over 130,000 searches to help them shop for health care services. We continue to evolve our program, and this year we will offer expert second opinions to allow those members with a complex diagnosis an opportunity to have their case and treatment plan reviewed by an expert physician in that field.

Together, these solutions have helped our employees decrease their health risk factors, reduce the number of chronic conditions, increase disease compliance and spend less time in the hospital.

In addition to our work on wellness at Caesars Entertainment, I would like to highlight a few of the programs at Business Roundtable member companies:

• Exelis Inc. launched a wellness program in 2012, which provides employees and their families with a variety of opportunities to learn about their current health statuses and take action to maintain or improve their health. Some of the results to date include, 43 percent of incentive-eligible members completing all activities to earn their full incentives, an increase in the percentage of participants who engaged in the recommended level of physical activity and modest improvements in some clinical indicators, including a nearly 5 percent increase in the number of individuals whose cholesterol and glucose levels are in the healthy range.

• In 2010, McKesson Corporation implemented a comprehensive wellness program through its partner vendor, Vitality. This program includes requirements for employees and spouses to complete a health assessment, biometric screening and certain other wellness activities to earn an incentive that reduces employees' contributions toward health care coverage. Among the results so far, in 2011, 83 percent of McKesson's eligible population had a "vitality age" (the measure of lifestyle

and biometric risks of a population) that was greater than their chronological age. In 2013, results improved to 77 percent.

• Rockwell Automation, Inc. believes that rewarding outcomes is the best way to achieve better outcomes. In 2010, the company increased its focus on promoting healthy lifestyles by introducing "Live Healthy" programs designed to reward not just health improvement, but health achievement. Today 88 percent of employees meet three or more healthy targets, resulting in a cumulative risk reduction of 9.5 percent over the past 4 years. The company says that its continued commitment to finding innovative solutions to balance costs and improve the health of its employees makes them a healthier company overall.

A full compendium of the programs designed to drive innovations in employer health care at Business Roundtable companies can be found in our report, *Driving Innovation in the Health Care Marketplace: A CEO Report.*

The sum of these efforts is a workforce empowered with the information they need to take control of their health and the tools to do so.

We believe that employer wellness programs provide significant potential for employees and their families. Further, we believe that over the long term, potential health care savings may come from behavioral changes, in which individuals become personally engaged by taking actions to avoid preventable conditions and detect other conditions as early as possible.

Mr. Chairman, thank you again for the opportunity to discuss the opportunities created by employer wellness programs today. We are encouraged by the bipartisan support for these programs in the *Affordable Care Act* and the continued bipartisan support for these programs within this committee. I am happy to answer any questions you may have.

The CHAIRMAN. Thank you, Dr. Loveman.

Dr. Baase.

STATEMENT OF CATHERINE M. BAASE, M.D., CHIEF MEDICAL OFFICER, THE DOW CHEMICAL COMPANY, MIDLAND, MI

Dr. BAASE. Good morning, Chairman Alexander, Ranking Senator Murray, and members of the committee. My name is Catherine Baase, and it is my great privilege to serve as the chief health officer for the Dow Chemical Company. I'm testifying today on behalf of my company and the American Benefits Council. My colleague, Janet Boyd, is the current chair of the board of this council.

I'm most grateful for the invitation to speak at this hearing. I have great passion and interest in the employer-based health efforts. In fact, I've spent nearly my entire professional career dedicated to this field and the advancement of the health of populations.

I expect that you are hearing much commentary, not only about the role of employer health efforts but also how health policy and actions of the EEOC might be impacting employers' ability to serve this vital role. I hope that my comments this morning will provide important perspective in this arena.

It's no surprise to anyone here that in this country and around the world, we have incredible health challenges. What you might not fully appreciate is how very important employers are to the solution. The most important message I want to share with you today is that successfully engaging employers as part of the overall societal effort to advance the health of our people is vital. In fact, I do not believe that we will achieve the public health objectives of this Nation without an effective effort by employers.

It is a national imperative, and we must find the best approach to involve our employers and support them in this critical action, and I am not alone in this view. National and international science

and policy organizations have concluded that employers and workplaces are absolutely essential to achieving health for society.

I would refer the committee to the November 2014 discussion paper of the McKinsey Global Institute which concluded that no individual sector in society on its own can address obesity. It requires the engagement of as many sectors as possible.

Although the McKinsey paper only addressed obesity, similar positions about health and chronic disease overall have been taken by the Institute of Medicine, the World Economic Forum, the Robert Wood Johnson Foundation, the World Health Organization, and many other science and policy organizations.

Now, Dow has had over 100 years of experience with the focus on the health of our people. We've had a formal health promotion effort in place for over 25 years, and a comprehensive corporate health strategy for more than 10. Over time, our health efforts have become woven throughout the fabric of our organization. They have become linked with safety efforts that include off-the-job safety. They've become a component of leadership development and employee training programs. Our strategy has even evolved to include collaboration with community health strategies.

While we do not use financial incentives to drive participation or outcomes in our global worksite health programs, the wellness component of our U.S. health care benefit plan does have a smoking surcharge. We rely on self-attestation for employees to report their smoking status and to report their participation in a tobacco cessation program to avoid that surcharge.

Our efforts are working. Since 2004, we have substantially improved the health risk profile of our global population, and Dow spent $4.8 million less in 2013 on its U.S. health care costs than we would have spent had we experienced the industry average trend.

As outlined in the Council's strategic plan, "A 2020 Vision," a critical component of encouraging employers to offer meaningful wellness programs is consistent Federal policy that promotes the health of Americans and is aligned across multiple agencies and Congress. I can understand why some employers are concerned with the legal uncertainty that exists with respect to the application of GINA and ADA to employer wellness programs. Employers should not have to face this confusion. We encourage Congress and the EEOC to work within existing HIPAA and ACA legislative and regulatory frameworks to provide certainty to employers.

To maintain global competitiveness and to achieve health in our communities, American companies must encourage healthy behavior with every tool in our toolkit. A healthy workforce is a productive one, and a productive workforce makes for a healthier American economy. Thank you.

[The prepared statement of Dr. Baase follows:]

PREPARED STATEMENT OF CATHERINE BAASE, M.D.

SUMMARY

National and international science and policy organizations have concluded that employers and workplaces are absolutely essential to achieving health for society. The business case for employer involvement in health has evolved and continues to advance. Population health is best achieved with business strategies that address employees as well as the community. Employers and vendors are making greater

use of population strategies and evidence-based approaches. The imperative for society is that we find the best way to support the business sector and keep employers engaged in effectively addressing the health of workers and their families.

Dow has over 100 years of experience with a focus on the health of our people. Over time, our health efforts became woven throughout the fabric of our organization. They became linked with safety efforts including off the job safety and they became a component of leadership development and employee training programs. We recognize that the health situation of the communities where we operate can be a great asset and a multiplier to our efforts.

While we do not use financial incentives to drive participation or outcomes in our global worksite health programs, we have a financial incentive—a smoking surcharge—for our medical plans ($50 per month) and dental plans ($10 per month). We rely on self-attestation for employees to report smoking status and participation in a tobacco cessation program to avoid the surcharge.

Our efforts are working. Since 2004 we have improved the health risk profile of our global population substantially. Dow spent $4.8 million less in 2013 U.S. health care costs than we would have spent had we experienced the industry average trend.

As outlined in the Council's recently released strategic plan, A *2020 Vision*, a critical component of encouraging employers to offer meaningful wellness programs is consistent Federal policy that promotes the health of Americans and is aligned across multiple agencies and Congress. Notwithstanding employers' increasing interest in establishing wellness programs and support for the PPACA wellness provisions, a great deal of legal uncertainty exists with respect to the application of both GINA and the ADA to these programs. The Council and Dow encourage Congress and/or the EEOC to work within the existing HIPAA and PPACA legislative and regulatory framework to provide certainty and flexibility to employers.

To maintain global competitiveness and help to achieve health in our communities, American companies must encourage healthy behavior with every tool in our toolkit. A healthy workforce is a productive workforce, and a productive workforce makes for a healthier American economy.

My name is Catherine Baase. I am the chief medical officer for The Dow Chemical Company ("Dow" or "the Company"). I am testifying today on behalf of my company and for the American Benefits Council (the "Council"). My colleague, Janet Boyd, currently serves as chair of the council's board of directors.

Dow, founded in Michigan in 1897, has become one of the world's leading manufacturers of chemicals and plastics. We supply products to customers in 160 countries around the world, connecting chemistry and innovation with the principles of sustainability to help provide everything from fresh water, food, and pharmaceuticals to paints, packaging and personal care products.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans. Many of the Council's members are at the forefront of the workplace wellness revolution, developing programs to help employees live healthier lives and manage chronic conditions.

Dow and the Council are strong supporters of employer-based wellness programs as an important tool for achieving better health outcomes for not only our employees but also our communities as a whole. According to the Kaiser Family Foundation's Employer Health Benefits 2014 Annual Survey, 98 percent of large companies (with 200 or more workers) and 73 percent of smaller companies in the United States offered at least one wellness program in 2014, and more than 75 percent of U.S. employees now have access to such programs.[1] [2] My testimony reviews both the recent studies supporting the need for employer engagement but also describes various types of employer-based programs and the need for strong public policy to support these programs.

CLEAR RATIONALE FOR EMPLOYER ENGAGEMENT

Key Points:

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[1] Kaiser Family Foundation, *Employer Health Benefits 2014 Annual Survey__Wellness Programs and Health Risk Assessments* 196 (2014) [hereinafter KFF Survey].

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

• Business/Employers are absolutely essential to society/countries achieving health for their people.
• Success in engaging the business community, with appropriate actions as part of a broad societal strategy to improve health, is an imperative.
• To have optimal impact, employers need to have a comprehensive health strategy.
• The insight and business case for employer involvement in health has evolved. The health of employees and the communities in which the business operates have connection to multiple business/employer priorities.
• It is possible to have a significant impact on the health of the employees through corporate health strategies and programs. The experience of Dow shares some of the impact of employer health strategies.

In November 2014, McKinsey Global Institute released a compelling document illustrating the overwhelming nature of the challenge our country faces with obesity and the importance of all sectors—including the business community—being involved if we hope to find a better future.[3] The McKinsey Global Institute (MGI) is the business and economics research arm of McKinsey & Company, which was established in 1990 to develop a deeper understanding of the evolving global economy. Its goal is to provide leaders in the commercial, public and social sectors with the facts and insights on which to base management and policy decisions. Its discussion paper provides a perspective on the nature and causes of the obesity problem and it provides recommendations. The report states,

> "Obesity is now a critical global issue, requiring a comprehensive intervention strategy rolled out at scale. More than 2.1 billion people—nearly 30 percent of the global population—are overweight or obese. That's nearly 2½ times the number who are undernourished. Obesity, which should be preventable, is now responsible for about 5 percent of all deaths worldwide. If its prevalence continues on its current trajectory, almost half of the world's adult population will be overweight or obese by 2030. This preliminary paper aims to start a global discussion on the components of a successful societal response."

In its executive summary, MGI makes several main points summarized as follows:

• Any single intervention is likely to have only a small overall impact on its own. A systemic, sustained portfolio of initiative, delivered at scaled is needed.
• Education and personal responsibility are critical but not sufficient. Changes to the environment and societal norms are also needed.
• No individual sectors in society—governments, retailers, consumer-goods companies, restaurants, employers, media organizations, educators, health-care providers or individuals—on their own can address obesity. Success requires engagement from as many sectors as possible—together.
• Implementing obesity abatement will not be easy; (1) deploy as many interventions as possible at scale, (2) understand how to align incentives and build cooperation and (3) do not focus unduly on prioritizing.
• The evidence based on clinical and behavior interventions is far from complete, proving a barrier to action; this need not be so. Experiment, rather than waiting for perfect proof.

As noted in the third bullet above, no individual sector in society, whether government, retailers, consumer-goods companies, restaurants, employers, media organizations, educators, health-care providers or individuals on their own can address obesity. It requires engagement from as many sectors as possible.

This McKinsey paper is focused on obesity. However, very similar reviews and positions have been taken by policy organizations and learned bodies about the ability to create healthy populations in general.

The World Economic Forum, in consideration of all non-communicable diseases, has stated that it is clear that chronic diseases are affecting social and economic capital globally. Non-communicable diseases are strongly connected to other global risks and fiscal crisis as well as underinvestment in infrastructure and food, water and energy security. The nature and extent of the challenges with non-communicable diseases will require the mobilization of social forces and people outside of health systems to make progress.[4]

The model of health created by the World Health Organization (WHO), and illustrated in their model, brings forward the concept that the approach to a healthy workplace includes an interface with the community, as noted in the Figure below.

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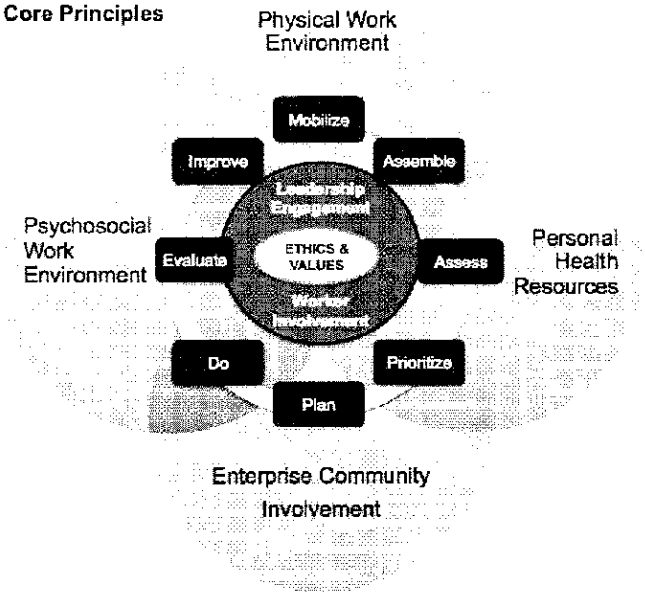
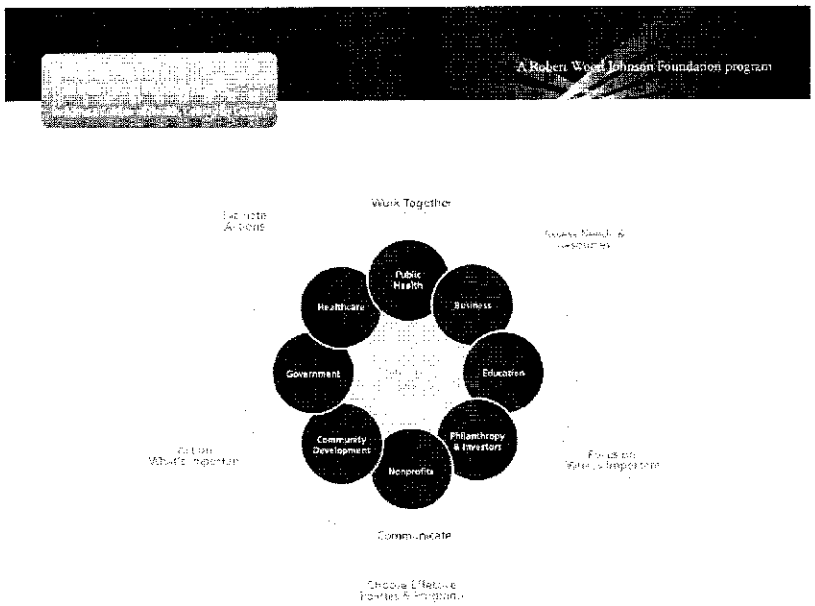
[3] McKinsey Global Institute, *Overcoming obesity: An initial economic analysis* (November 2014).
[4] World Economic Forum, *Global Risks 2010* (2010).

Figure ES1
WHO Healthy Workplace Model: Avenues of Influence, Process, and Core Principles



The Roadmaps to Health program from the Robert Wood Johnson Foundation also notes the business community as a core element of the method to achieve healthier communities through collective impact as noted here and taken from its Web site.[5]

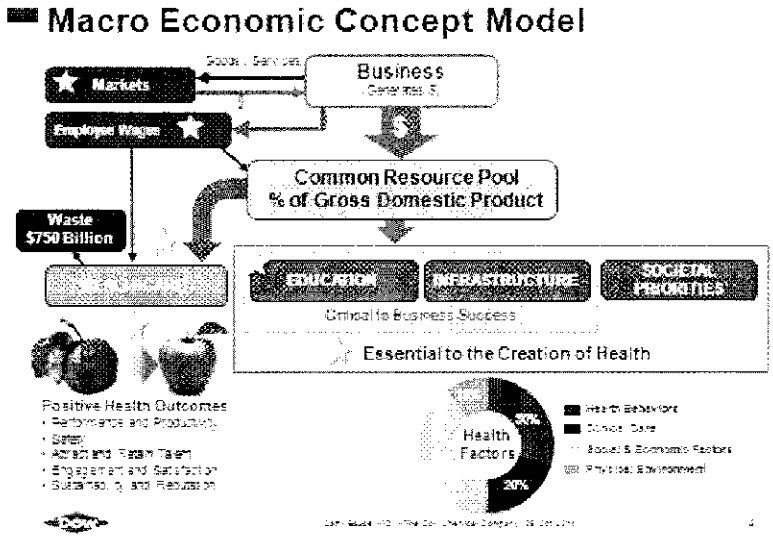
[5] *http://www.countyhealthrankings.org/resources/101-presentation.*



The Institute of Medicine, as a part of the National Academy of Sciences, has convened a Population Health Roundtable (the "Roundtable"), of which I am privileged to be a member. The Roundtable has considered for over a year the nature of the situation this country faces in addressing the health of populations, the multiple causes and factors which are at work in creating health or lack of health and the path forward to a better future. They, too, have determined that it will take the engagement of multiple sectors of society to make progress, and that includes the business community/employers. In July 2014, this Roundtable convened a workshop entitled "Business Engagement in Population Health Improvement," which further explored the rationale, opportunity and case examples of the business/employer community and their beneficial impact not only on their own employees but also the families of those employees and the communities where they operate.[6]

During this July workshop, I presented a view of the rationale for business engagement in health broadly by illustrating the nature of the current situation and the multiple pathways through which the current policy environment is adverse to business success, using the macroeconomic model below, which highlights the alignment of business priorities and health.

[6] Institute of Medicine, *Business Engagement in Building Healthy Communities: Workshop Summary* (July 2014).



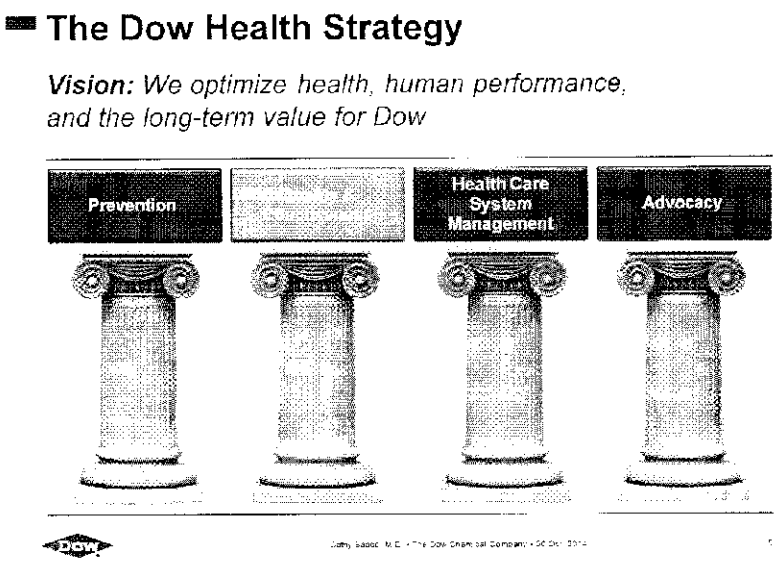
One of the challenges in population health is that no single entity feels ownership of, or has responsibility or accountability for taking control and finding solutions. The task now is to create collective ownership of population health and engage people from all sectors, including the business community.

The Macroeconomic Concept Model (the "Model") focuses on how business generates money in society. Some of that money is used to pay employee wages and some percentage, in the form of taxes, goes into a common resource pool. A portion of the employee wages also contributes to the shared resource pool of taxes serving the needs of society. The Model illustrates six key ways in which the current health scenario is negatively impacting the success of the business sector. A better understanding of how the Model's elements are destructive to a business's success should motivate the business community to become more engaged. The six elements are:

- **Wage compression:** Increasing health care costs are resulting in wage compression; that is, a greater percentage of total compensation is going toward health care benefits versus take-home wages. This can be an issue in the ability to attract and retain global talent as well as achieve satisfaction and better morale in the workplace.
- **Reduced profits:** A greater percentage of total funds generated by business have to be allocated toward health care, resulting in reduced profits. Further, the significant waste in the healthcare system means that dollars invested to achieve health are not delivering high value.
- **Eroded foundation for business:** Money from the common resource pool funds health care as well as education, infrastructure, and other social priorities. Education and infrastructure are essential foundation elements for the success of business; however, they are being undermined by the diversion of greater and greater percentages of the societal resource base toward health care.
- **Less healthy workforce:** Business also needs healthy people in order to be successful. The unfortunate reality is that the increasing expenditures on healthcare are not delivering greater health for our population. Relative to other developed countries our people are losing ground on health markers. As businesses invest significantly in their employee base, they hope to have the full potential of those workers to achieve their goals. Diminished health impacts performance potential.
- **Impact on elements essential to the creation of health:** The same elements that are essential to business such as education are important social determinants of health. Diversion of spending away from education and infrastructure also undermines the creation of health.
- **Diminished purchasing power:** The cumulative impact of the current scenario is a diminished market because there is less take-home pay, and less disposable income.

What employers really want is better health for their people and the communities in which they operate, better quality of care overall and better value for their dollars spent in pursuit of health.

At Dow, we have over 100 years' experience with a corporate focus on the health of our people. We have had a formal health promotion initiative for nearly 30 years. Our efforts have been recognized as innovative and successful by numerous organizations all over the world. Over 10 years ago, we established the Dow Health Strategy as a formal corporate level strategy. This strategy was built upon a comprehensive business case and is graphically illustrated below. Our actions within the strategy are focused in four key areas: prevention, quality and effectiveness of care, health system improvement and advocacy.



Subsequent to developing the initial health strategy design, we have had continued insight and evolution of the business case and our action plan. Since our formal health promotion programs started, we have had comprehensive programs covering a broad array of prevention topics and utilizing a portfolio of methods from education to health assessments and counseling to group classes and targeted campaigns. We set policies like a tobacco policy. Over time, the health efforts became woven throughout the fabric of the organization. They became linked with safety efforts including off the job safety; they became a component of leadership development and employee training programs. We became intentional about setting a positive culture and environment for health including development of a corporate food philosophy and joint efforts with our facilities function to explore sit/stand desks and other aspects of our building design and management which can impact health.

At this point, our business rationale links our health focus to many corporate priorities including safety, attracting and retaining talent, employee engagement and job satisfaction, corporate social responsibility, sustainability and profitability. This alignment of organizational priorities and the benefits of a healthy population reinforce the importance of healthy people to an organization. Thus, the value to the organization is broad and includes a serious focus on healthcare costs but much more.

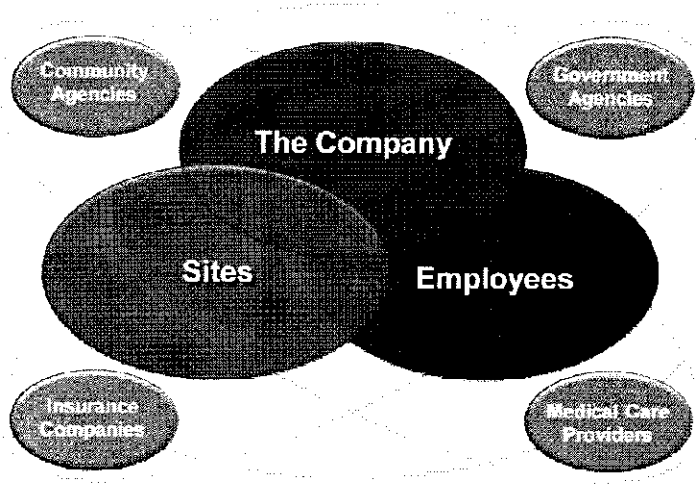
Organizational Priorities: Broadened Alignment for Health

- Health Care Costs
- Safety
- Reliability
- Human Capital Priorities
  - Engagement
  - Talent: Attract and Retain
  - Human Performance
- Sustainability
- Corporate Social Responsibility
- Corporate Reputation

We also recognize that in our pursuit of the goals of our health strategy, the communities within which we operate and the health situation of those communities can be a great asset and a multiplier to our efforts. We see the benefit of constructive collaboration with our communities.

We see our strategy as one of shared responsibility, as illustrated in the following diagram:

Shared Responsibility



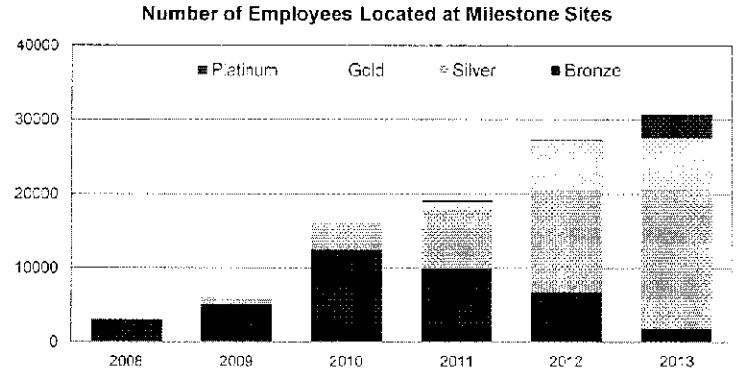
As we pursued a "Culture of Health" several years ago, we launched an effort called the Healthy Workplace Index. This tool assigns scores for key elements and a cumulative score—Bronze, Silver, Gold or Platinum—for each Dow site in the United States and throughout the world. The use of this index is completely voluntary for each site, yet it has been widely used by the majority of sites across the country. The elements of the index are illustrated by the following diagram:

Healthy Workplace Index – Key Elements

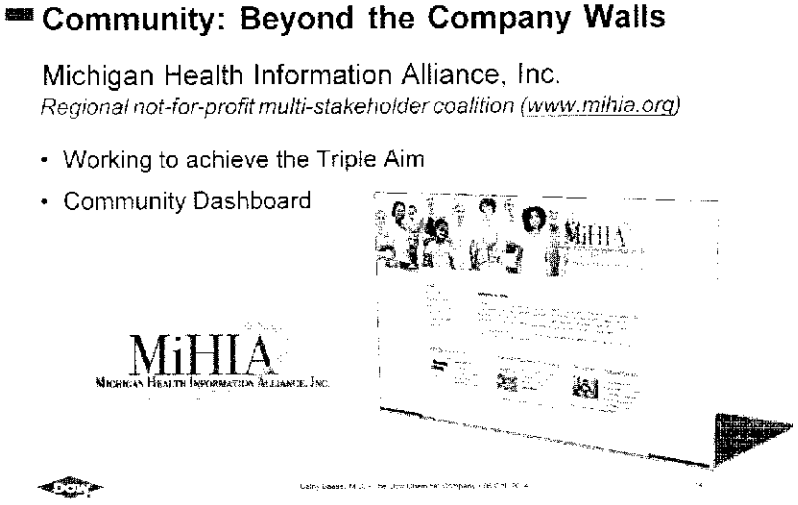
- Tobacco Policy enforcement
- Access to physical activity
- Access to healthy foods
- Case management
- Periodic health assessment participation
- Company directed exam participation
- Stress management
- Supportive work environment (composite index)

The following chart shows the progress in achievement over time of scores and the increasing number of sites achieving higher milestones.

Healthy Culture: Healthy Workplace Index Progress



We recognized the power of culture and environment in supporting healthy lives. As we worked to create and strengthen this culture in our workplaces, we began to bring into our view the opportunity to collaborate with others to create a community of health excellence where we operate. One example of this collaborative effort with the community is the Michigan Health Improvement Alliance serving 14 counties in central Michigan around our corporate headquarters. Since 2007, we have worked in a collective impact approach with all sector stakeholders in these counties. Through MiHIA, our communities are currently pressing to reduce waste and improve care through the "Choosing Wisely" campaign of the American Board of Internal Medicine Foundation. We are working to change the health system in our region to move upstream in the disease process by establishing a new norm and processes to identify and intervene to address pre-diabetes using the CDC's evidence based intervention known as the Diabetes Prevention Program. More detailed information on the progress of this multi-stakeholder effort is available on the Web site.[7]



DOW'S SYSTEM FOR MEASURING IMPACT AND APPROACH TO USE OF INCENTIVES

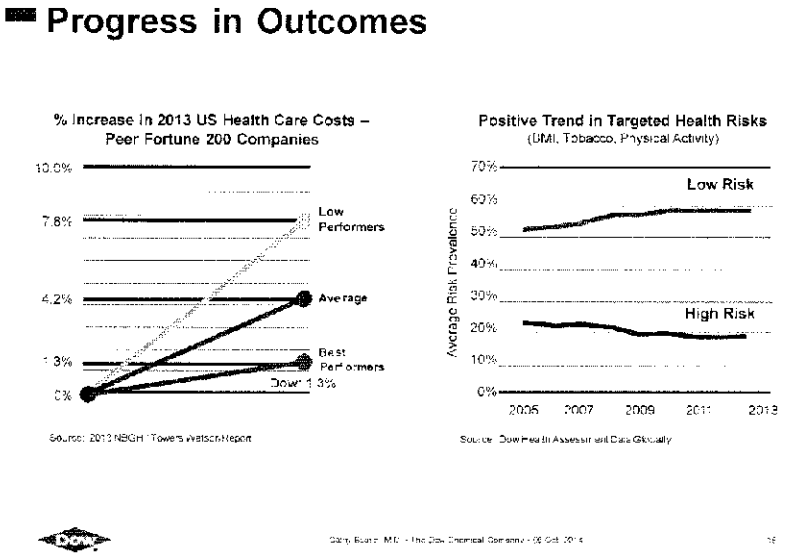
Throughout our corporate health efforts, we have implemented extensive measures to track outcomes. We track progress across our sites around the world. Participation in our health promotion programs is voluntary. We do not use financial incentives to drive participation or outcomes in our global worksite health programs. Our employees value the services we offer and the programs available to them. Our global participation rates are very high—approaching 90 percent for completion of health assessments.

However, in our U.S. healthcare benefit plan, we do have one financial incentive. On January 1, 2010, we introduced a smoking surcharge for our medical plans ($50 per month) and dental plans ($10 per month). Of course one of the goals was to discourage smoking but the other purpose was just to recognize the increased cost of medical and dental coverage for a tobacco user. The surcharge can be avoided by agreeing to attend a tobacco cessation class. In the case of reporting smoking status and the report of attendance at a tobacco cessation class, both are self-attestation.

The impact of our efforts is evidenced in the graphic below. Specifically, the graph shows our experience in U.S. health care spending and our experience worldwide in tracking our top three priority health risks since 2004. Due to our 1.3 percent trend in 2013, Dow spent $4.8 million less in 2013 U.S. health care costs than we would have spent had we experienced the industry average trend of 4.2 percent. Our 5-year trend is less than 2 percent. Recognizing favorable trend compounding over the last 5 years, we spent $44.8 million less in 2013 than we would have spent in 2013 had we experienced average trend over the last 5 years.

[7] *http://www.mihia.org.*

Regarding health risks, since 2004 we have seen a more than 15 percent increase in the percent of our employee population at low risk for BMI, physical activity and tobacco and a 28 percent decrease in the employee population at high risk for these same three risk factors. Further, a 2012 study conducted by Towers Watson comparing our population to peer companies with adjustments for demographics and other variables found that our entire covered lives in the U.S. healthcare plans population had a 9 percent better health risk profile than their book of business and our prevalence of chronic conditions was 17 percent less than others while we spent 17 percent less on chronic conditions.



OVERVIEW OF THE CURRENT STATE OF EMPLOYER SPONSORSHIP OF WELLNESS PROGRAMS

Experiences of other employers with wellness programs also evidence positive results. A global survey by Buck Consultants, representing the views of 1,041 employer respondents based in 37 countries, states the leading results of wellness programs are "reducing sick leave" and "presenteeism" (the practice of attending work while sick), and "improving workforce morale and engagement."[8]

Data from the 2013 RAND Employer Survey, sponsored by the U.S. Department of Labor, suggest that employers view the impact of their wellness programs overwhelmingly as positive, with 78 percent stating that it decreased absenteeism and 80 percent stating that it increased productivity.[9]

A 2013 Society of Human Resource Management (SHRM) Survey reported that three quarters (76 percent) of employers said their wellness initiatives are "somewhat" or "very effective," [10] while 32 percent of respondents to a 2014 Mercer Survey said specifically that the health risks of the population served by their wellness programs were improving.[11] These results support published research findings that workplace wellness programs can improve health status, as measured with physiological markers (such as body mass index, cholesterol levels and blood pressure).[12]

[8] Buck Consultants, *Working Well: A Global Survey of Health Promotion and Workplace Wellness and Productivity Strategies, Executive Summary* 2 (2014).
[9] RAND, *Workplace Wellness Programs Study: Final Report* 53 (2013).
[10] Society of Human Resource Management, *State of employee benefits in the workplace—Wellness initiatives* 4 (2013).
[11] Mercer, *Taking health management to a new level* (2014) via Sloan Center, *supra* note 2, at 3.
[12] RAND, *supra* note 4 at 61.

Like Dow's experience, other employers' programs hold the promise of more direct economic benefits under the principle that successful preventive actions, better-managed chronic conditions and fewer episodes of care will result in reduced health service utilization and fewer claims. The Buck Consultants study found that per-employee per-year health care costs were identified as a valuable outcome by 68 percent of employees.[13]

Indeed, the RAND study found that while it is not clear at this point whether improved health-related behavior will translate into lower health care cost, there is reason to be optimistic. Fully 60 percent of respondents indicated that their wellness program reduced health care cost,[14] with reductions in inpatient costs accounting for 68 percent of the total cost reduction, compared to outpatient costs (28 percent) and prescription drug costs (10 percent).[15]

EMPLOYERS' PROGRAM DESIGNS VARY

Employers have developed a variety of wellness program designs. The most common offerings generally include:

- immunizations/flu shots (53 percent of all firms, 87 percent of large firms);
- web-based resources for healthy living (39 percent/77 percent);
- wellness newsletters (34 percent/60 percent);
- employee assistance programs ("EAPs") (29 percent/79 percent);
- gym membership discounts or onsite exercise facilities (28 percent/64 percent);
- smoking cessation programs (27 percent/64 percent);
- biometric screening programs (for blood pressure, cholesterol, glucose, and body fat) (27 percent/51 percent);
- lifestyle or behavioral coaching (23 percent/58 percent);
- nutrition/healthy living classes (20 percent/47 percent); and
- weight-loss programs (19 percent/48 percent).[16]

Many of these design elements are also common to value-based insurance designs (V–BID), which are related to wellness programs in that they also make use of financial incentives to increase health outcomes, similar to how Dow implemented our smoking incentive relating to our premium levels. For example, in one study, completion of a health risk assessment was a V–BID participation requirement for 26 percent of companies; participation in a disease management, weight management or tobacco cessation program was a requirement for 29 percent of companies.[17]

Additionally, many employers expand these programs to the family members of their employees. The Buck Consultants survey found that 62 percent of programs include spouses, 52 percent include domestic partners and 43 percent include children.[18] A separate study found that 17 percent of firms offer wellness programs to their retirees.[19]

The evidence base regarding workplace health promotion has evolved and continues to advance. Employers and vendors are making greater use of population strategies and evidence-based approaches. There is more advanced thinking to create cultures which advance health. Organizations are increasing their sophistication in establishing comprehensive efforts and an overarching health strategy. Consistent with the Center for Disease Control and Prevention's "Health in All Policies" efforts, the worksite is a critical venue to address health needs and health improvement. Advanced approaches to population health in communities with an emphasis on Patient Centered Medical Homes, are working to make sure that the "medical neighborhood" is functioning in a strong manner knowing that everything cannot be accomplished in a physician's office. All of this underscores the importance of supporting and keeping employers engaged in addressing health. It matters to society and to the quality of life of those in the workforce.

CHALLENGES WITH CURRENT PUBLIC POLICY

Employers applaud Congress for working on a bipartisan basis to craft the wellness provisions in the Patient Protection and Affordable Care Act (PPACA) that built on the existing framework created in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PPACA's bipartisan provision increased employer

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[13] Buck Consultants, *supra* note 3, at 4.
[14] RAND, *supra* note 4 at 53.
[15] RAND, *supra* note 4 at 57.
[16] KFF Survey, *supra* note 1, at 199. Similar results also available from Optum, *Fifth Annual Wellness in the Workplace Study: An Optum Research Update* 5 (2014)
[17] Aon Hewitt, 2014 Health Care Survey 33 (2014).
[18] Buck Consultants Survey Executive Summary, *supra* note 3, at 3.
[19] Optum, *supra* note 12 at 7.

flexibility in designing programs to improve the health of employees and their families. Additionally, the PPACA has helped to cement wellness programs as one of the cornerstones of health reform.

A critical component of encouraging employers to offer meaningful wellness programs is consistent Federal policy that promotes the health of Americans and is aligned across multiple agencies and Congress. We welcome the opportunity to work with this committee, the Equal Employment Opportunity Commission (EEOC) and other stakeholders to provide legal and regulatory certainty to employers offering wellness programs to their employees.

Legal Landscape

Wellness programs are subject to the jurisdiction of the Department of Labor ("DOL"), the Department of the Treasury ("Treasury"), the Department of Health and Human Services ("HHS"), and the EEOC via a range of Federal statutes and regulations. Many States have laws governing wellness programs, as well. The discussion below sets forth the basic Federal legal framework applicable to the oversight of wellness programs. This is not intended to be an exhaustive discussion of all Federal legal issues related to wellness programs but rather to provide a basis for understanding compliance and other issues employers face with regard to wellness programs.

Health Insurance Portability and Accountability Act of 1996

For years, wellness programs have been subject to extensive regulation by the DOL, HHS, and Treasury by virtue of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191 ("HIPAA"). HIPAA provides privacy and nondiscrimination protections to consumers in connection with group health plans.

Specifically, Titles I and IV of HIPAA added certain provisions to the Internal Revenue Code ("Code"), the Employee Retirement Income Security Act ("ERISA"), and the Public Health Service Act ("PHSA").[20] These provisions are generally intended to prohibit group health plans and group health insurance issuers from discriminating against individuals in eligibility, benefits, or premiums based on a health factor, which includes, among other things, disability.[21] An exception to the general rule allows premium discounts, rebates, and cost-sharing modifications (all forms of incentives or rewards) in return for adherence to certain programs of health promotion and disease prevention, such as a wellness program.[22]

Final regulations issued by the DOL, HHS and Treasury to implement these provisions of HIPAA took effect in 2007, and impose rules that certain wellness programs must satisfy in order to allow incentives to be provided to participants.[23] Programs that either do not require an individual to meet a standard related to a health factor in order to obtain a reward or that do not offer a reward at all ("participatory wellness programs") are not subject to the additional rules if participation in the program is made available to all similarly situated individuals.[24] Programs that require individuals to satisfy certain health factor standards in order to obtain a reward ("health-contingent wellness programs") must satisfy a host of requirements in order to satisfy the HIPAA nondiscrimination rules.[25]

The requirements are intended to prevent discrimination in the use of incentives in connection with wellness programs based on a health factor such as disability. In particular, the requirements that a wellness program (1) "not be a subterfuge for discriminating based on a health factor, and not be highly suspect in method," and (2) the requirement that a "reasonable alternative standard (or waiver of the otherwise applicable standard)" be provided to individuals for whom it is unreasonably difficult due to a medical condition to satisfy the standard or for whom it is medi-

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[20] *See* Code § 9802, ERISA § 702, PHSA § 2705.

[21] *See* Code § 9802(a)(1) (" . . . a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on . . . [d]isability." Other health factors are: (i) health status, (ii) medical condition (including both physical and mental illnesses), (iii) claims experience, (iv) receipt of health care, (v) medical history, (vi) genetic information, and (vii) evidence of insurability (including conditions arising out of acts of domestic violence).

[22] Code § 9802(a)(1).

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

[24] *See* 26 C.F.R. § 54.9802–1(f)(1). Examples of participatory wellness programs include reimbursement of gym memberships, diagnostic testing that does not condition receipt of reward on attainment of certain outcomes, and a program that reimburses employees for the costs of smoking cessation programs regardless of whether an employee stops smoking.

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

cally inadvisable to attempt to satisfy the standard each provide stringent protections to individuals with disabilities.

Patient Protection and Affordable Care Act

Congress signaled its strong support for the use of wellness program incentives and the protections provided in the current HIPAA nondiscrimination rules in a bipartisan provision of the PPACA. Specifically, PPACA Section 1201 codifies the HIPAA regulations and increases the permitted incentive from 20 percent to 30 percent (and permits regulators to increase incentives up to 50 percent in their discretion). This is a rare bipartisan provision in the controversial health care reform law and reflects Congress's approval of the offering of incentives for health-contingent wellness programs.

On June 3, 2013, the DOL, HHS and Treasury issued final rules on "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans."[26] These new final HIPAA wellness rules are based on the same general framework as the existing HIPAA wellness rules and incorporate changes that were mandated by the PPACA, including increased limits on the amount of health-based wellness program rewards that a plan can offer or penalties it can impose.

Under the PPACA—as under the previous HIPAA rules—plans first must determine whether their wellness program is Participatory or Health-Contingent. A program will be considered Participatory if none of the conditions to obtain a reward are based on an individual satisfying a health standard, and thus participatory programs are not required to meet the HIPAA wellness rule requirements. Health-Contingent programs must meet the additional requirements of the HIPAA wellness rules in order to be in compliance with the HIPAA nondiscrimination rules. A wellness program is considered to be Health-Contingent if it requires an individual to satisfy a standard related to a health factor in order to obtain a reward. The June 2, 2013, final rules break the Health-Contingent category down further into Activity-Based and Outcome-Based, with different requirements for each depending on the type of program.

The PPACA has helped to cement wellness programs as one of the cornerstones of health reform. In addition to the express codification of the HIPAA wellness program regulations in PPACA Section 1201 discussed above, there are numerous other provisions relating to wellness initiatives in the PPACA, including:

- Employer wellness program evaluation tools.[27]
- Health plan quality-of-care report and employee notice.[28]
- Small-employer wellness program grants.[29]

These provisions are inextricably linked to the fundamental fabric of the PPACA and indicate the clear intent of Congress and the Obama administration that wellness programs should be analyzed, studied and incorporated into the new reformed health care system, and that the employer role in sponsoring wellness plans should be supported.

Genetic Information Nondiscrimination Act of 2008

Wellness program design and implementation is also shaped by the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110–233 ("GINA"). Title I of GINA, which is under the jurisdiction of DOL, HHS and Treasury, addresses whether and to what extent group health plans may collect or use genetic information, including family medical history. Title II of GINA, under the jurisdiction of EEOC, restricts how employers and certain other "covered entities" (collectively referenced herein as "employers" for purposes of clarity) may collect and disclose genetic information and prohibits employers from using genetic information in employment decisions.

Title I: Title I of GINA amended the Code, ERISA, and the PHSA to prohibit discrimination in health coverage based on genetic information. Interim final rules were published in the Federal Register on October 7, 2009.[30] Title I of GINA, in relevant part, prohibits group health plans and health insurance issuers in the group and individual markets from discriminating against covered individuals based on genetic information. Title I applies to a wide variety of group health plans, including wellness programs that constitute or are related to group health plans. Title

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[26] 78 Fed. Ref. 33158
[27] PPACA §§ 4303, 10404.
[28] PPACA § 1001.
[29] PPACA § 10408.
[30] Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. 51,664 (Oct. 7, 2009).

I generally prohibits a group health plan and a health insurance issuer in the group market from:

- increasing the group premium or contribution amounts based on genetic information;
- requesting or requiring an individual or family member to undergo a genetic test; and
- requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.[31]

The prohibition on requesting, requiring or purchasing genetic information at any time for underwriting purposes affects wellness programs. The term "underwriting purposes" is defined broadly to include rules for eligibility for benefits and the computation of premium or contribution amounts, and it does not merely encompass activities relating to rating and pricing a group policy.[32] The regulations clarify that the term "underwriting purposes" includes changing deductibles or other cost-sharing mechanisms, or providing discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing an HRA or participating in a wellness program.[33] "Genetic information" is defined for purposes of GINA Title I to include family medical history.[34]

Wellness programs cannot provide rewards for completing HRAs that request genetic information (including family medical history), because providing rewards would violate the prohibition against requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes. A plan or issuer can collect genetic information through HRAs under Title I of GINA as long as no rewards are provided for such genetic information (and if the request is not made prior to or in connection with enrollment).[35] A plan or issuer can provide rewards for completing an HRA as long as the HRA does not collect genetic information.

Title II: Title II of GINA, which is under EEOC's jurisdiction, restricts how employers may collect and disclose genetic information and prohibits employers from using genetic information in employment decisions. Final regulations under Title II were published in the Federal Register on November 9, 2010.[36]

The final Title II regulations provide that it is unlawful for an employer to discriminate against an individual based on his or her genetic information with regard to, among other things, privileges of employment.[37] Where a wellness program is considered to be a privilege of employment, the sponsoring employer may be subject to regulation under Title II with respect to the wellness program.

Title II generally prohibits employers from requesting, requiring or purchasing genetic information of an individual or a family member of the individual. An exception is provided where health or genetic services are offered by the employer, including where they are offered as part of a wellness program, if the employer meets certain requirements:

- The provision of genetic information by the individual is voluntary, meaning the covered entity neither requires the individual to provide genetic information nor penalizes those who choose not to provide it;
- The individual provides prior knowing, voluntary, and written authorization, meaning that the covered entity uses an authorization form that (1) is written in language reasonably likely to be understood by the individual from whom the information is sought, (2) describes the information being requested and the general purposes for which it will be used, and (3) describes the restrictions on disclosure of genetic information;
- Individually identifiable genetic information is provided only to the individual (or family member and the health care professional or genetic counselor providing services); and
- The information cannot be accessed by the employer (except in aggregate terms).[38]

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

[32] Code § 9832(d)(10)(B).

[33] 26 C.F.R. § 54.9802–3T(d)(1)(ii); 29 C.F.R. § 2590.702–1(d)(1)(ii); 45 C.F.R. § 146.122(d)(1)(ii).

[34] 26 C.F.R. § 54.9802–3T(a)(3); 29 C.F.R. § 2590.702–1(a)(3); 45 C.F.R. § 146.122(a)(3).

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

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

[37] *See* 29 C.F.R. § 1635.4.

[38] *See* 29 C.F.R. § 1635.8(b)(i). See also Commission Informal Discussion Letter (June 24, 2011), *http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html.*

Incentives may not be offered for individuals to provide genetic information.[39] Thus, an employer may offer an incentive for completing an HRA (a common component of wellness programs) that includes questions about family medical history or other genetic information, provided that the employer specifically identifies those questions and makes clear, in language reasonably likely to be understood by those completing the HRA, that an individual need not answer the questions that request genetic information in order to receive the incentive.

In addition, the final regulations provide that an employer may offer an incentive to encourage individuals who have voluntarily provided genetic information that indicates they are at increased risk of acquiring a health condition in the future to participate in disease management programs or other programs that promote healthy lifestyles, and/or to meet particular health goals as part of a health or genetic service. However, to comply with Title II of GINA, these programs must also be offered to individuals with current health conditions and/or to individuals whose lifestyle choices put them at increased risk of developing a condition but who have not volunteered genetic information.[40]

Americans with Disabilities Act

The EEOC also regulates wellness programs pursuant to Title I of the Americans with Disabilities Act ("ADA"). Title I of the ADA prohibits discrimination against qualified individuals with disabilities.[41] The ADA prohibits employers from conducting medical examinations or making inquiries regarding disabilities at any point during the hiring process or during employment, with certain limited exceptions.[42]

Title I of the ADA allows employers to conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at a work site. Any medical information acquired as part of the program is kept confidential and separate from personnel records. There is little guidance regarding what the term "voluntary" means in this context.

The EEOC has issued numerous informal discussion letters that generally provide that a wellness program is considered voluntary as long as an employer neither requires participation nor penalizes employees who do not participate.[43] The EEOC has stated in certain of these informal discussion letters that it has not taken a position on whether, and to what extent, Title I of the ADA permits an employer to offer financial incentives for employees to participate in wellness programs that include disability-related inquiries (such as questions about current health status asked as part of an HRA) or medical examinations (such as blood pressure and cholesterol screening to determine whether an employee has achieved certain health outcomes). The EEOC has also issued Enforcement Guidelines providing, among other things, that a wellness program is voluntary as long as an employer neither requires participation nor penalizes employees who do not participate.[44]

The EEOC has, on at least two occasions, come close to providing clarifying guidance. In 1998, the EEOC stated in an informal discussion letter that "[i]t could be argued that providing a monetary incentive to successfully fulfill the requirements of a wellness program renders the program involuntary" and that "where an employer decreases its share of the premium and increases the employee's share, resulting in a significantly higher health insurance premium for employees who do not participate or are unable to meet the criteria of the wellness program, the program may arguably not be voluntary."[45]

In addition, on March 6, 2009, the EEOC rescinded part of a January 6, 2009, informal discussion letter which provided, in part, that:

> [A] wellness program would be considered voluntary and any disability-related inquiries or medical examinations conducted in connection with it would

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[39] *See* 29 C.F.R. § 1635.8(b)(2)(ii).
[40] 29 C.F.R. § 1635.8(b)(2)(iii).
[41] 42 U.S.C. § 12112(a).
[42] 42 U.S.C. § 12112(d).
[43] *See* Commission Informal Discussion Letter (Jan. 18, 2013), *http://www.eeoc.gov/eeoc/foia/letters/2013/ada_wellness_programs.html*; Commission Informal Discussion Letter (June 24, 2011), *http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html*; Commission Informal Discussion Letter (May 6, 2009), *http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html. See also* American Bar Ass'n, Questions for the EEOC Staff for the 2009 Joint Committee of Employee Benefits Technical Session (2009), *http://www.abanet.org/jceb/2009/EEOC2009.pdf*.
[44] *See* Equal Employment Opportunity Comm'n, Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA), Q&A 22 (2000), *http://www.eeoc.gov/policy/docs/guidance-inquiries.html*.
[45] *See* Commission Informal Discussion Letter (Jan. 23, 1998) (on file with Council).

not violate the ADA, as long as the inducement to participate in the program did not exceed 20 percent of the cost of employee only or employee and dependent coverage under the plan, consistent with regulations promulgated pursuant to the Health Insurance Portability and Accountability Act.[46]

Although rescinded, the above language indicates that the EEOC has at least contemplated allowing a certain level of incentives to be offered in connection with disability-related inquiries or medical examinations conducted in connection with a wellness program. It further indicates that the EEOC has, on at least this one occasion, looked to HIPAA guidance to shape the contours of the ADA.

At least partly as a result of the EEOC's silence, the Eleventh Circuit weighed in on the treatment of wellness programs for purposes of the ADA. The particular concern has to do with a common design that conditions receipt of an incentive upon mere participation rather than outcomes-based wellness programs. In *Seff* v. *Broward County*,[47] the Eleventh Circuit upheld the district court's decision as to whether a participatory wellness program satisfied the ADA where it imposed a $20 charge on each biweekly paycheck issued to employees who enrolled in the group health insurance plan but refused to participate in the County's wellness program, which required in part that employees complete online HRAs and take blood tests to measure their glucose and cholesterol levels. Employees diagnosed with asthma, hypertension, diabetes, congestive heart failure or kidney disease were given the opportunity to receive disease management coaching and certain free medications related to those conditions. Instead of looking at whether the wellness program is "voluntary" within the meaning of Title I of the ADA, the court relied on other provisions in the ADA (a provision creating a safe harbor for "bona fide benefit plans") to find that the wellness program complied with the ADA. We note that, despite the decision in *Seff*, the EEOC's regional offices continue to undertake enforcement actions based on the "voluntary" standard and employers do not have the guidance from the EEOC necessary to comply with the ADA.

KEY CONCERNS FOR EMPLOYERS AND POLICY RECOMMENDATIONS

Notwithstanding employers' increasing interest in establishing wellness programs, a great deal of legal uncertainty exists with respect to the application of both GINA and the ADA to these programs. As noted above, existing guidance from the EEOC is not clear regarding what constitutes a voluntary wellness program for purposes of the ADA. Moreover, questions remain regarding how GINA applies to various aspects of some common wellness program designs, including the use of wellness incentives in connection with spousal and dependent HRAs.

The Council testified before the EEOC[48] in a May 2013 hearing, describing employers' strong concern about the ongoing legal uncertainty that exists with respect to the application of the ADA and GINA to wellness programs. The Council also urged "Federal agencies promulgating regulations should proceed in a consistent, collaborative manner that supports participatory and outcomes-based wellness initiatives" in our new strategic plan, *A 2020 Vision*.[49]

This legal uncertainty has been exacerbated by certain enforcement actions initiated by regional offices of the EEOC with respect to employers' HIPAA and PPACA-compliant wellness programs. Recent enforcement actions brought by the EEOC allege certain wellness programs violate the ADA and GINA by imposing penalties on employees who decline participation in the company's biometric screening program. These legal actions have had a chilling effect on employer wellness programs.

Additionally, the EEOC announced in its most recent semi-annual regulatory agenda that it intends to issue regulations later this year addressing wellness programs under the ADA and GINA. However, the actual timetable for the issuance of such guidance is uncertain.

Unfortunately for employers operating in good faith, the EEOC decided to pursue litigation before issuing guidance on this matter. This is very frustrating for employers who care about the well-being of their employees and take seriously their compliance obligations. It is impossible for employers to abide by rules that do not exist.

The unfortunate result of continued legal uncertainty would be that many American workers who could benefit from access to meaningful wellness would be left without.

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[46] *See* Commission Informal Discussion Letter (Mar. 6, 2009), *http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.*

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

[48] *http://www.americanbenefitscouncil.org/documents2013/wellness_eeoc_council-simon-testimony050813.pdf.*

[49] *http://www.americanbenefitscouncil.org/newsroom/2020vision.cfm.*

Recommendation: Building on HIPAA's Framework

It is my hope that this testimony has strongly reinforced the imperative to support and strengthen the efforts of employers to be effective in their role of advancing the health of people. The Council and Dow encourage Congress and/or the EEOC to work within the existing HIPAA and PPACA legislative and regulatory framework to provide certainty to employers. HIPAA imposes a robust set of nondiscrimination rules on issuers and employers with respect to a very broad class of persons—effectively any group health plan participant that has a health status or condition, even where such status or condition falls short of constituting a disability for purposes of the ADA. In other words, HIPAA already casts a broad protective net—one that not only protects individuals with disabilities, but also the American worker or health plan participant more generally.

As mentioned, the EEOC announced in its most recent semi-annual regulatory agenda that it intends to issue regulations later this year addressing wellness programs under the ADA and GINA. We fully respect the EEOC's existing and longstanding authority to implement and enforce the ADA, as well as other Federal statutes. As the committee considers possible further wellness program standards or other legislative parameters applicable to the EEOC, we urge you to recognize the comprehensive regulatory framework that already exists, including protections for individuals with disabilities and beyond. The employer community appreciates this committee's recognition of the importance of wellness programs and the existing regulatory framework that protects consumers, and notes PPACA was amended on a bipartisan basis to endorse and expand HIPAA-compliant wellness programs.

We believe that the HIPAA regulatory framework is both comprehensive and practical, and if the committee or the EEOC concludes that improvements are needed, all interested parties should come together in a meaningful and measured fashion to carefully consider the effects of changes to this existing framework.

If this committee considers advancing legislation pertaining to wellness programs, it would be helpful to provide relief from certain provisions of the ADA and GINA to employers that are complying with HIPAA and PPACA.

For example, with respect to Health-Contingent wellness programs (including Activity-Based and Outcome-Based programs), legislation could deem such programs to comply with the ADA to the extent the program complies with existing HIPAA and PPACA regulations. With respect to participatory programs, such programs could be deemed to comply with the ADA, provided the program is reasonably designed to promote health or prevent disease and the program does not use a reward that exceeds 30 percent of the total premium cost (or up to 50 percent at the regulator's discretion). With respect to all three categories of programs (i.e., participatory, Activity-Based and Outcome-Based programs), legislation could also specify that such programs would not be found to violate GINA solely because a program requests current medical information from a participant's spouse (or vice-versa) so long as the information is used solely with respect to the participant's spouse.

CONCLUSION

There is no single tactic for Dow's success or the successes of other employer programs. Rather, a collective solution is needed, focused on each company's health opportunity. For Dow, the solution includes an integrated Health Strategy, comprehensive health programs, two decades of sustained commitment and a major focus within our culture. As the Council's *A 2020 Vision* states, employer-sponsored benefit plans are now being designed with the express purpose of giving each worker the opportunity to achieve personal health and financial well-being. This well-being drives employee performance and productivity, which drives successful organizations. To maintain global competitiveness and help to achieve health in our communities, American companies must encourage healthy behavior with every tool in our toolkit. In other words, a healthy workforce is a productive workforce, and a productive workforce makes for a healthier American economy.

Thank you for your interest in employer-sponsored wellness programs. I appreciate the opportunity to testify, and the Council and I look forward to working with you to restore certainty to employers focusing on improving the health of their workforces.

The CHAIRMAN. Thank you, Dr. Baase.

Dr. Grossman.

STATEMENT OF DAVID C. GROSSMAN, M.D., M.P.H., MEDICAL DIRECTOR FOR POPULATION AND PURCHASER STRATEGY, GROUP HEALTH RESEARCH INSTITUTE, SEATTLE, WA

Dr. GROSSMAN. Good morning, Chairman Alexander, Ranking Member Murray, and members of the committee. Thank you very much for inviting me to testify here at this important hearing today. My name is David Grossman, and today I'm representing Group Health Cooperative, which is a large integrated health system in the State of Washington that takes care of about 600,000 people in our State. We're a provider of care, a health plan, and also an employer, and as such, we have a unique perspective on this issue given that we take care of patients, that we take care of the populations of our purchasers, and also our own employees who deliver those services.

At Group Health, I'm the medical director for population health and purchaser strategy, where I work together with the purchasers on helping to design these programs. I'm also a researcher at the Group Health Research Institute and a faculty member at the University of Washington. While I'm not here in that capacity, I also serve on the Community Preventive Services Task Force and am the incoming Vice Chair for the U.S. Preventive Services Task Force.

Today I have three main points and two brief stories, and my three main points are these.

First, as a Nation, we do have more work to do on worksite health. The worksite is a great opportunity, as we've heard, to improve the health of our Nation. There's no question in my mind about that. And there are many successful examples out there, yet a lot still remains to be done to fully actually realize this promise, not only with large employers, who we hear a lot about, but also smaller employers, small businesses and medium-sized businesses, many of whom have yet to engage in this type of effort. We recognize this through our dealings with purchasers at Group Health, and I know my colleagues also see this. So we do support efforts to extend the reach of well-designed programs throughout the Nation.

My second point is, we'll get there faster if we use what we already know and then invest in filling the gaps for where we do have knowledge gaps. There's been a lot of variation in the design and fidelity of execution of these programs, and those that have succeeded, as some we're hearing about today, in delivering on improved health and productivity, and perhaps sometimes health care costs too, are those that generally implement based on best practices and good evidence.

Group Health considers itself a learning health care system, in the parlance of the Institute of Medicine, and as such, we all know that we can stand to learn more about how to improve as new evidence emerges.

My third point is engagement is key, but I don't just mean engagement for the employee. I mean employers engaging their staff in the design and execution of wellness programs, that employees engage with managing their own health in partnership with their providers, and that employers, plans, health care systems and pro-

viders need to engage with each other to ensure that incentives are aligned so that we get to the right place and do the right thing.

Financial incentives are just one part of that equation as a success factor, and that's what we try to do at Group Health as an integrated system, is to try to make sure that those incentives are aligned.

OK. Now, the stories. One is about my county Senator Murray talked about, and the second is about Heidi.

King County Government is a national leader in worksite health programs, especially for the public sector. They call their program Healthy Incentives, and we took a lot of inspiration from King County in the design of our own program at Group Health. We did it by changing the culture, the environment, and by providing economic incentives to motivate behavior change. And Group Health was proud to be a partner in this effort because we take care of one-third of their employees and their families, and we brought programs to them that enabled the facilitation of receipt of those services.

The results are really impressive. King County employees and their families lost 19 tons of weight, and smoking prevalence dropped by over 6 percentage points. Their own economist estimated that they saved $46 million in health care costs through this program over the years, to date. And they were the recipient of Harvard's Innovation in Government Award for the work that they've done. So I'm proud to say that I live in a county that has such a forward-thinking government, and also an employer.

My second story is about Heidi. Heidi works with me at Group Health and was concerned about the impact of her weight on her health but could never really quite get to the point of acting on it. With our Total Health program at Group Health and incentives to participate in our onsite program, she was able to transform her life by losing 30 pounds, or over 15 percent of her body weight, in a healthy way. She felt so much younger, energetic, athletic; and most importantly, she has learned how to manage her weight toward the future so she doesn't necessarily need to rely on others to get her there.

There are many people like Heidi around America who have benefited from having an employer who takes an interest in their health thanks to an evolving science that's getting a lot of traction.

Thank you, Chairman Alexander, Ranking Member Murray, and members of the committee for your time, and I look forward to your questions.

[The prepared statement of Dr. Grossman follows:]

PREPARED STATEMENT OF DAVID C. GROSSMAN, M.D., M.P.H.

SUMMARY

The worksite offers us a tremendous opportunity in our work to improve health in the United States. However, there is significant variance in workplace wellness programs and their effectiveness. To be effective, workplace wellness programs should be: (1) focused on improved employee health and productivity in their goals and (2) evidence-based in their design and practices. There is still much to learn about how best to incent and engage employees in efforts to improve their health.

Fortunately, we do have resources to help guide these efforts. The Community Preventive Services Task Force and the U.S. Preventive Services Task Force both provide a wealth of evidence-based information online, at no cost, regarding effective health promotion programs and appropriate screenings.

King County, WA, as an employer, offers a great example of an effective workplace wellness program. Working in partnership with Group Health, organized labor, and other expert stakeholders, King County designed their "Healthy Incentives℠" program on two goals: (1) creating a culture of health in the workplace to make healthier employee behavioral and lifestyle choices easier and normative, and (2) encouraging employee consumption of evidence-based clinical preventive services and chronic condition management. Financial incentives help to nudge employees toward making the right choices.

The county's healthcare economist reports that through improved health of employees and use of higher quality health care, the county has reduced its health care cost trend from 11 percent to 6.2 percent, avoiding $46 million in costs. Employee engagement has been at or above 90 percent since the program began. Participants have lost 19 tons more weight than a national comparison group, and the smoking rate has dropped below the national average from 11.3 percent to less than 5 percent. The Healthy Incentives program has won a variety of national awards, including Harvard University's Innovations in Government award.

The most effective workplace wellness programs will likely share King County's two-pronged focus: (1) impacting employee behavioral and lifestyle choices, and (2) impacting employee uptake of evidence-based clinical preventive services such as cancer and blood pressure screening. Indeed, King County found that the highest-quality health care (using evidence-based preventive services)—as rated by the Washington Health Alliance and provided by Group Health—saved the county more than $4,200 per employee per year. Linking worksite health programs with high quality clinical care delivery, such as medical homes, synergizes the impact of these programs.

The most important success factor for workplace wellness programs is also the most difficult to achieve—meaningful engagement by employers with health systems and by employees with their own health. Financial incentives such as premium discounts seem to be an effective way to "nudge" employees toward better health, though more evidence is needed to determine how successful these efforts are, with whom they are successful, and what amounts encourage engagement. There are a variety of other potential approaches toward using incentives that researchers are currently exploring. Employers and health systems must work together to design programs that work to make employees healthier and more productive, thereby reducing costs to both employees and employers. Long-term healthcare cost trends should be moderated by reducing risk factors and delaying the onset of chronic illnesses in the population.

Chairman Alexander, Ranking Member Murray and members of the Senate Health, Education, Labor, and Pensions Committee, thank you for inviting me to testify at this important hearing on workplace wellness programs.

My name is David Grossman, and I am medical director of Population Health and Purchaser Strategy at Group Health Cooperative in the State of Washington. Group Health is an integrated health system—by which I mean we provide both direct care and plan coverage. We cover about 600,000 lives in Washington and Idaho and rank among the highest-quality plans and health systems in the country, as measured by the Centers for Medicare and Medicaid Services' star rating system, the National Committee for Quality Assurance, the Washington Health Alliance's Community Checkup, and others. In my role at Group Health, I lead the design, promotion, delivery, and evaluation of population care services, and I work with large purchasers in their efforts to design benefits and programs that maximize health and effectively steward resources. Additionally, I serve as a senior investigator at Group Health Research Institute and practice pediatrics part-time at a Group Health medical center in Seattle. I am also a member of the Center for Disease Control's Community Preventive Services Task Force, and I am the incoming vice-chair of the U.S. Preventive Services Task Force.

The health care we receive determines only a small percentage of our health. By some estimates, only about 10 percent of an individual's health is determined by the care he or she receives; the rest is dictated by behavior, genetic predisposition, social circumstances, and environmental exposure.[1] This means that there are many places other than a doctor's office that an individual's health can be affected. As a pediatrician, I've seen firsthand how school-based health programs and embedded clinics have made an incredible positive difference in childhood health throughout the country. From requiring and providing immunizations to offering care in school-

[1] McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Affairs (Millwood) 2002; 21(2):78–93.

based health clinics, over the years we've changed young lives by making prevention, wellness and chronic condition management accessible in a place where we know children spend a significant part of their day. At Group Health, we believe, as our large purchasers also tell us, that the worksite offers a similar opportunity for health promotion.

As an example, at Group Health Research Institute, I work with an analyst named Heidi Merrifield. In 2012, Heidi was feeling tired a lot. It was getting tougher to move around, but she told herself it was just the inevitable impact of turning 50. At more than 220 pounds, Heidi was close to her highest weight ever, but she had never seriously considered joining Weight Watchers or another formalized weight loss program. With her long commute on top of a long work day, Heidi couldn't imagine how she would find time, and the programs seemed expensive as well. She figured she knew how to lose weight if she really wanted to. But she didn't act on it.

Then Heidi discovered that Group Health's "Total Health" employee wellness program would significantly reduce her health insurance premiums if she undertook certain wellness activities, including participation in Weight Watchers. Group Health would, in addition, reimburse her for half the cost of participating in the program. She also discovered she had the option of meeting with a Weight Watchers group at work. While she wasn't particularly hopeful, she says Group Health made it so easy, she had to try.

Heidi learned a lot about herself and her eating habits, and eventually she lost 33 pounds. Heidi reports she felt like age 25 again. She has more energy, she's more agile, and at 53, she requires no medications. She and her husband have always loved sailing, and Heidi says it's even more fun with her increased dexterity and strength. Heidi says now even when her weight starts to inch back up, she understands what to do to stay healthy and knows she has the skills and motivation to do it.

Group Health, as an employer, benefits too, given the strong association between obesity and health care costs, absenteeism, and presenteeism.[2] Employees who are engaged in their health care are also more productive and positive at work, contributing to a stronger workplace overall.

It's a simple story. It's not particularly dramatic. But I believe its simplicity, and the science behind it, make it replicable. Heidi lost a significant amount of weight and got healthier just because her workplace wellness program made it easy and incented her to do so; you can see why at Group Health, we believe the worksite offers a tremendous opportunity for improving health and well-being.

There is good science behind programs that engage employees to improve their health by reducing risk factors for heart disease, diabetes, and cancer through increasing time in health promoting activities and receipt of clinical preventive services.[3]

With that said, it's important to note that today there is tremendous variation in workplace wellness programs across the country—and that means that it's likely there is an equally large amount of variation in their effectiveness. Just like clinical care, these programs are best positioned to deliver when they are based on good science and are well executed and coordinated.

Financial incentives are a common approach toward the initial engagement of employees. We all know that economic incentives can be a powerful way to get attention and even change behavior. Incentives vary considerably. One company may offer a free t-shirt to employees who report eating more vegetables. Another may provide an Amazon gift card for filling out a Health Screening Assessment (HSA). And others may tie it to health benefits and offer a more financially significant premium discount for participating in wellness programs in other ways, or for meeting certain outcome-based goals (e.g., weight loss or reducing blood pressure). Though one study[4] showed about half of employers in 2013 offered workplace wellness ini-

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[2] Goetzel, Gibson, Short, Chu, et al. A Multi-Worksite Analysis of the Relationships Among Body Mass Index, Medical Utilization, and Worker Productivity. Journal of Occupational and Environmental Medicine 2010; 52 Suppl 1: S52-S58.

[3] Centers for Disease Control and Prevention. Benefits of Health Promotion Programs. Accessed online January 25, 2015 at *http://www.cdc.gov/workplacehealthpromotion/businesscase/benefits/index.html*.

[4] Mattke, Liu, Caloyeras, Huang, Van Busum, Khodyakov, and Shier. Workplace Wellness Programs Study: Final Report. RAND Health for the U.S. Department of Labor and the U.S. Department of Health and Human Services. Accessed online January 22, 2015 at *http://www.rand.org/content/dam/rand/pubs/research__reports/RR200/RR254/RAND__RR254.sum.pdf*.

tiatives of some kind, there is a lot of variation. This makes measuring effectiveness and standardizing best practices difficult.

Premium discounts are an increasingly popular tool for employers to incent employees to participate in wellness programs. Since 2006, rules issued under the Health Insurance Portability and Accountability Act (HIPAA) have generally prohibited group health plans and insurers from discriminating against participants as to eligibility, benefits, or premiums based on a health factor. However, an exception was created to allow premium discounts, rebates, or modification of cost sharing for employees participating in workplace wellness programs. The Affordable Care Act amended and expanded the HIPAA rules, most notably by increasing the maximum permitted financial incentives from 20 percent of the total annual cost of employee-only coverage to 30 percent.

One common requirement to receive premium discounts is completion of a health risk assessment (HRA). The HRA is a common screening tool that allows assessment of an individual's specific health risks and chronic conditions, which supports individualized action plans to address risks and manage conditions. At Group Health, we encourage all of our patients to complete HRAs; we also use HRAs as a tool in our organizational wellness program.

At Group Health, we believe there are two basic principles to guide wellness programs to success. First, we believe successful workplace wellness programs should have a clear primary goal: improved worker health and productivity. Employers, therefore, may or may not experience reduced health care costs. The best evidence indicates that employers are most likely to benefit from improved productivity—whether they benefit from reduced future health care claims is less clear and subject to substantial variation.

In Group Health's own employer-sponsored wellness program, "Total Health," we work very hard to ensure that the means to achieving the goal of improved health and productivity are never a threat to the privacy of an employee's health information; nor are they discriminatory in nature. Privacy, nondiscrimination, and engagement incentives are issues that every workplace wellness program must address.

Second, workplace wellness programs should be evidence-based whenever possible. The number of wellness vendors seems to be increasing by the day—each with its own approach for pursuing good health. But greater scrutiny is required to ensure success and avoid unnecessary services; for example, a company that requires lipid screenings for grocery store clerks of all ages really isn't adding value to employee health. And in the 2013 RAND Employer Survey, while "employers overwhelmingly expressed confidence that workplace wellness programs reduce medical cost, absenteeism, and health-related productivity losses," only half reported formally evaluating program impacts, and "only 2 percent reported actual savings estimates."[5] There is clearly room for more rigorous study and evaluations, as these will be important to building programs that work to improve health for large numbers of workers.

Happily, there is already a good deal of unbiased evidence available for clinicians, communities, and employers to use in building and judging wellness initiatives.

The Centers for Disease Control and Prevention supports the Community Preventive Services Task Force (CPSTF) to provide a "Community Guide"—evidence-based guidance to policymakers, practitioners, program planners, and other decision-makers in communities, including companies, schools, public health agencies, health care institutions, and health plans, at the local, State, and Federal levels. The scientific literature tells us that worksite programs can indeed lead to engagement and improved health. The Community Preventive Services Task Force recommends the use of assessments of health risks with feedback when combined with health education programs, with or without additional interventions, on the basis of strong evidence of effectiveness in improving one or more health behaviors or conditions in populations of workers. Additionally, the Task Force recommends the use of assessments of health risks with feedback when combined with health education programs to improve the following outcomes among participants:

- Tobacco use (strong evidence of effectiveness);
- Excessive alcohol use (sufficient evidence of effectiveness);
- Seat belt use (sufficient evidence of effectiveness);
- Dietary fat intake (strong evidence of effectiveness);
- Blood pressure (strong evidence of effectiveness);
- Cholesterol (strong evidence of effectiveness);
- Number of days lost from work due to illness or disability (strong evidence of effectiveness);

[5] Mattke, et al., p. xix.

- Health care services use (sufficient evidence of effectiveness); and
- Summary health risk estimates (sufficient evidence of effectiveness).

Again, health assessments are often considered the portal to worksite wellness programs, given that interventions should be tailored to a person's need and risks.

The U.S. Preventive Services Task Force (USPSTF), supported by the Agency for Health care Quality and Research, provides complementary evidence-based recommendations on clinical preventive services for patients. Their recommendations are typically used in primary health and health care-referable settings by clinical care professionals and decisionmakers. But since these recommendations address screening, such as blood pressure or blood lipids, they form the basis of worksite programs that offer onsite screening and referral programs.

In addition to offering our own employee wellness program, Group Health actively works with employers who want to offer worksite wellness programs. Our goal, as an integrated system, is to make sure that incentives are aligned at all levels—the worksite, the health plan and the medical provider—to maximize success.

One of the most successful and recognized employer wellness programs in the country is found in King County, WA, where Seattle is the county seat. The King County government, under the leadership of former King County executive Ron Sims, created its "Healthy Incentives℠" workplace wellness program in 2005. According to the county, Healthy Incentives was created based on two principles.

> "First, an environment that supports health empowers lifestyle changes that reduce the impact of chronic conditions.
>
> "Second, integrated care that focuses on preventive, evidence-based medicine produces better outcomes and is less expensive."[6]

Creating an environment that supports health and lifestyle changes wasn't easy—but the county worked collaboratively with organized labor and worker representatives with a focus on improving health rather than shifting costs. According to King County,

> In 2005, the county negotiated an agreement with labor unions to overhaul its medical plan design. The obvious strategy for stemming rising costs was [instituting] a health care premium [cost-share for the first time]. Instead, the county offered lower out-of-pocket expenses for employees participating in wellness activities; the higher the level of participation, the lower the member's out-of-pocket expenses. The new plan was introduced to employees in 2006. Participants get a substantial reduction in out-of-pocket expenses for taking a health risk assessment and even lower for participating in an action plan targeting behavior-related health risks.[7]

The county worked aggressively to build a new culture of health in the workplace for employees. "Wellness programs like Weight Watchers at Work® were brought onsite, healthy food options were put in vending machines, and ongoing education on nutrition and exercise were launched through a newsletter and Web site."[8]

King County also worked closely with Group Health to drive costs down by extending high-quality health care to more workers. Group Health has consistently been rated the highest-quality provider in the region by the non-profit Washington Health Alliance, and claims data demonstrated that employees using Group Health as their provider cost the county about $4,200 per employee less annually, even though the quality of care was much higher. In 2009, Group Health served only about 20 percent of county employees, so the county created more incentives for its workers to obtain higher-quality care. The county eliminated the deductible for employees who chose Group Health and lowered copayments for those who participated in the Healthy Incentives program. Group Health has long offered free preventive care benefits and had a medical home model, so employees engaged in their program received great reinforcement for their health care needs at our medical centers. Continued support for screening services, immunizations or smoking cessation could all be fulfilled through, and reinforced by, their medical home provider.

Group Health also brought lifestyle management programs that had proven successful in a clinical setting into the King County workplace. Despite initial concerns that the "Better choices, better health" program for living well with chronic conditions might not translate outside the clinical setting, the program has been a great success.

In the end, according to the County the results—in measurably improved health—have been nothing short of stunning:

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[6] King County application, Harvard Innovations in Government Award.
[7] Ibid.
[8] Ibid.

> Through improved health of employees and use of higher quality health care, the county has reduced its health care cost trend from 11 percent to 6.2 percent, avoiding $46 million in costs. Employee engagement has been at or above 90 percent since the program began. Participants have lost 19 tons more weight than a national comparison group, and the smoking rate has dropped below the national average from 11.3 percent to [less than 5 percent].[9]

The Healthy Incentives program has been recognized with the National Committee for Quality Assurance's Health Quality Award, the National Association of Counties' 2006 Achievement Award, and more recently with Harvard University's Innovations in Government award. We believe that King County, working closely with Group Health, has delivered abundantly on the promise of workplace wellness programs and preventive care.

There are two keys to success in creating a high-value worksite health promotion program and they are found in the goals King County embraced at the Healthy Incentives program's outset: (1) creating a culture of health in the workplace to make healthier employee behavioral and lifestyle choices easier and normative, and (2) encouraging employee consumption of evidence-based clinical preventive services and chronic condition management. Financial incentives help to nudge employees toward making the right choices.

Group Health's own workplace wellness program, "Total Health," is one example of the kind of program that is making progress toward building a culture of health at the worksite. The program includes making healthier choices at work easier (e.g., offering no-cost Quit for Life® phone counseling for smoking cessation, subsidizing Weight Watchers at Work for employees, and offering healthier choices in vending machines). It also uses significant premium discounts—up to $750 annually—based on screenings and self-guided participation in selected wellness activities focused mostly on cardiovascular risk reduction. More than 80 percent of Group Health employees participate in Total Health, with stories like Heidi's becoming more and more common. Like King County, we designed Total Health with labor organizations at the table to ensure our goal of improved employee health remained paramount. It wasn't always easy, but in the end, we designed an evidence-based program whose outcomes are currently under study by the Group Health Research Institute.

Of course, in addition to being an engaged employer sponsor of Total Health, Group Health is also an integrated health system eager to engage with other employer sponsors to ensure employees have access to high-quality, high-value preventive services and a patient-centered medical home model.

We believe the integrated nature of the Group Health system—with our reach into not just the plans sold, but the provider system—gives us the ability to collaborate with purchasers in designing truly individualized solutions to their workplace wellness and prevention needs.

In fact, Group Health recently worked closely with one purchaser—the SEIU Healthcare NW Benefits Trust—to address high emergency department and hospital utilization. Working together, we devised a unique approach to addressing the problem. The Trust offered $100 to any worker who completed three tasks: (1) registering with Group Health's online member portal; (2) completing a health risk assessment; and (3) making one preventive office visit. Surfacing health issues through an HRA and establishing a relationship with a primary care provider made a remarkable difference; these simple steps (over a 4-year period) led to a 27 percent reduction in emergency department and a 14 percent reduction in hospital admissions.

This example illustrates an important point—meaningful engagement by employers with health systems and by employees with their own health are critical success factors for workplace wellness programs. King County and the SEIU Healthcare NW Benefits Trust offer powerful examples of very engaged employers who have created their own very significant positive outcomes.

Of course, health systems also must be willing to engage with employers in innovative, individualized approaches; today many health systems are simply not prepared to have a conversation with their purchasers about new ways to serve employee health promotion needs. Until incentives are fully aligned through the marketplace, we expect the engagement with health systems will progress slowly.

My message today is not that all or even most workplace wellness programs are effective, but that carefully designed, evidence-based programs with the primary goal of improved employee health can demonstrate dramatic results to reduce risk and improve health, often improving worker productivity at the same time. The in-

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[9] King County application, Harvard Innovations in Government Award and Vestal, Christine.

credible variance in programs, vendors, employers and research on workplace wellness prevent any blanket conclusions about program effectiveness.

I commend this committee for hosting this discussion and encourage further study of the issue in pursuit of the most effective paths to success. I urge more high-quality research on program outcomes so that evidence may guide our decisions, answering important questions about the necessity and size of incentives to improve health, the qualities that will encourage meaningful engagement by employees, and the most effective protections against discrimination and on behalf of consumer privacy.

The CHAIRMAN. Thank you, Dr. Grossman.

Mr. Abernathy.

STATEMENT OF JAMES MATTHEW ABERNATHY, NASHVILLE, TN

Mr. ABERNATHY. Good morning, Chairman Alexander and Ranking Member Senator Murray, and members of the committee. My name is Matt Abernathy. I work in Nashville, TN for Blue Cross Blue Shield of Tennessee, and I've been there 12 years. I'm here today with my wife Holly and my children Shannon and Ian.

In 2003 at age 21, I weighed 250 pounds. My doctor told me I was at high risk for premature heart attack. I had high cholesterol, high blood pressure, and was pre-diabetic. This bothered me, but not enough to do anything about it. Four years later, when our daughter Shannon was born, I realized it was time to change things if I wanted to be around to see her grow up. I also wanted to be a role model for her to see how to live so that she wouldn't face the same challenges that I faced throughout my life. I decided to take responsibility for my own health and make choices accordingly.

From there, I chose to start a run/walk program. I started learning about healthy diet. Two years later Ian was born, and for the same reasons as when Shannon was born, I knew that these changes had to become a way of life.

The support for these choices came first and foremost from my wife, Holly. She's been there through everything from meal planning to keeping me motivated when things seemed too difficult, to instilling the values in our children.

Also, support came from the resources provided by Onlife Health. My employer, Blue Cross Blue Shield of Tennessee, has a voluntary wellness program that is provided by Onlife. Early in my career at Blue Cross I had participated in the program, but it wasn't until after the birth of Shannon that I began to take it seriously and start to utilize the resources available to me. With the goal of making my life better for me and my family, I took full advantage of Onlife's wellness program. I was provided the tools I needed to set goals, track my progress, make changes, and stay on track. These included free annual health assessments and biometric screenings, a secure online wellness portal for 24/7 access, health coaching, electronic pedometer, as well as walking programs.

The health coaches encouraged me to get moving and become active. They provided accountability as well as educational material and expert input.

Still today, I continue to use Onlife's wellness portal to track my progress and stay in touch with my health coaches. The financial incentives that Blue Cross offers further motivates me and rewards me for doing healthy activities. These incentives are tied to partici-

pation in various programs offered by Onlife Health. Additionally, I receive discounts and rebates on my health insurance for my participation in these events.

Overall, this wasn't an overnight fitness program. This has been an ongoing commitment and a deliberate lifestyle transformation for me. Today, my kids have a dad who is fit and healthy. I weigh now 188 pounds. I've completed six half-marathons and two full marathons. My workplace wellness program gave me a support system to help me succeed.

As a result of my healthy lifestyle, my children will not face many of the struggles that I had to deal with in my past. They understand good food choices and moderation.

I'm thankful for my wife, my workplace wellness program, my health coaches who have helped me change from an overweight, at-risk employee into a picture of health. Thank you, and I'll be happy to answer any questions.

[The prepared statement of Mr. Abernathy follows:]

PREPARED STATEMENT OF JAMES MATTHEW ABERNATHY*

SUMMARY

My name is James Matthew Abernathy. I work in Nashville, TN as a Regional Service Coordinator for BlueCross BlueShield of Tennessee. I am 32 years old and have worked at BlueCross since 2002.

Today, I am "a picture of health," according to my doctors. However, that description did not fit me just a few years ago. In 2003, I weighed 250 pounds, drank 4 to 5 sodas a day, and did not exercise at all. After completing a health assessment, doctors told me I was a high-risk for a heart attack.

After the birth of my daughter, Shannon, in 2007, I made the decision to change my life. I realized that if I wanted my children's lives to be different than mine that I would have to change my unhealthy habits and break the cycle.

My wife, Holly, is my rock at home. But I have been lucky because I also receive the help I need from my employer. BlueCross BlueShield of Tennessee has a wellness program that is provided by Onlife Health. Early in my career at BlueCross I had participated in the program, but after the birth of Shannon, I went all in. The Onlife program and their professional health coaches not only changed my life, they saved my life.

With a goal of making life better for me and my family, I took full advantage of Onlife's comprehensive wellness program. It starts with a health assessment that includes a biometric screening to measure my weight, blood pressure, cholesterol, glucose levels, and other fitness indicators. Over the years, I have worked with great health coaches who encourage me, take the time to learn my personal goals, and help me set realistic action plans to achieve those goals. My coaches encouraged me to get moving and to become active. The company set up a walking program. They provided employees with pedometers and rewarded us for reaching step goals.

The financial incentives the company offers further motivate and reward me for doing healthy activities. Incentives are tied to participation in the various programs offered by Onlife. For example, we are rewarded up to $200 per quarter for reaching our step goals, and I receive discounts on my health insurance.

Today, my kids have a dad who is fit and healthy. I have completed 6 half-marathons and 2 full marathons. My weight is down to 188 pounds. My workplace wellness program gave me the support system I needed to succeed. It made me realize that I wasn't in this alone, that I could get help whether I was at work or at home. And it is contagious. I have many friends and co-workers who have become more active and fit.

As a result of my new lifestyle, my children will not face many of the struggles I had to deal with in the past. They understand good food choices and moderation. I'm thankful for my wife, my workplace wellness program, and my health coaches

*Disclaimer: Mr. Abernathy's testimony is his own account of a personal wellness journey which included participation in a formal workplace wellness program. Mr. Abernathy's outcomes are not meant to be representative of, nor can they be reasonably expected for participants in this or similar workplace wellness programs.

who helped me change from an overweight, at-risk employee into a picture of health.

Chairman Alexander, Ranking Member Senator Murray, and, members of the committee.

Good morning. Thank you for the opportunity to share my story about the benefits I received by participating in my company's voluntary wellness program as part of a culture of wellness at my workplace. My name is James Matthew Abernathy. I work in Nashville, TN as a Regional Service Coordinator for BlueCross BlueShield of Tennessee. With me today are my wife, Holly, my daughter, Shannon, and my son, Ian.

I am 32 years old and have worked at BlueCross since 2002. Today, I am very pleased to be described as "a picture of health," by my doctors. That's a statement I am very proud of. However, it is also a statement that did not apply to me just a few years ago.

In 2003, doctors described my condition much differently. I weighed 250 pounds, indulged in unhealthy eating and snacking, drank 4 to 5 sodas a day, and did not exercise at all. After completing a health risk assessment, doctors told me I had high blood pressure, was pre-diabetic, and was a high-risk for a heart attack. At the time I was 21 years old and didn't want to listen. So I did what many people do when hearing these kinds of warnings. I didn't go back to my doctor for a number of years.

Things changed after the birth of our daughter, Shannon, in 2007. That's when I made the realization that I had to change. I wanted to improve for my own benefit and for my family. I realized that if I wanted my children's health and their lives to be different than mine that I would have to change my unhealthy habits and break the cycle. My wife, Holly, was and continues to be my No. 1 fan. She supports me, motivates me, and inspires me.

Holly is my rock at home. But I have been lucky because I also receive the help I need from my employer. BlueCross BlueShield of Tennessee has a wellness program that is powered by Onlife Health. Early in my career at BlueCross I had participated in the program, but after the birth of Shannon, I went all in. The Onlife program and their professional health coaches not only changed my life, they saved my life.

The wellness program consisted of a number of elements that helped me recognize the unhealthy habits that I had developed, and the options and resources available to me to break those habits and learn new ones. I learned that becoming healthy overnight was not realistic, that it would take time, a commitment on my part, personal accountability, and replacing the unhealthy habits with healthy ones. That meant eating better, being more active, getting more rest, and reducing stress.

With a goal of making life better for me and my family, I took full advantage of Onlife's comprehensive wellness program. It started by taking a health risk assessment that included a biometric screening to measure my weight, blood pressure, cholesterol, glucose levels, and other fitness indicators. The screenings were conveniently done right at my office, and they were free. From the health assessment, my health profile was established. Over the years, I have worked with great health coaches who encourage me, take the time to learn my personal goals, and help me set realistic action plans to achieve those goals. That includes information about proper nutrition . . . what to eat and drink . . . and learning that moderation is key. It wasn't that I couldn't eat snacks or even drink a soda now and then. My coaches taught me to eat sensible snacks and foods that were good for me, and to avoid those that were not good for me.

My coaches encouraged me to get moving and to become active. The company set up a walking program and invited employees to track the number of steps we took each day. They provided us with pedometers and rewarded us for reaching step goals. Onlife Health helped me keep track of everything on their secure wellness portal. I can go online anytime and find educational materials about fitness, message my health coach, or track the number of Life Points and other incentives that I have earned.

The financial incentives the company offers further motivate and reward me for doing healthy activities. Incentives are tied to participation in the various programs offered by Onlife. For example, we are rewarded up to $200 per quarter for reaching our step goals, and I receive discounts on my health insurance.

Today, the financial incentives are secondary to me; my main motivation is maintaining a healthy lifestyle for me and my family. Shannon and Ian now have a dad who is fit and healthy. I have completed 6 half-marathons and 2 full marathons. My weight is down to 188 pounds and I am training to run the toughest trail mara-

thon in the country, the Savage Gulf Marathon in Beersheba Springs, TN, in March. My wife, Holly, is a runner too, and even our 7-year-old enjoys getting out and competing in fun runs, 5Ks and such. What has become a big transformation in my life is now a part of my children's lives.

It's incredible to see this. What was MY wellness journey has become a wellness journey for our entire family.

A few years ago, I was overweight and unhealthy——now I'm not. I never thought I could be healthy. I thought that was something for "other guys." I thought it was something only maintained by elite thin people with active families. Now, I know that's not true.

My workplace wellness program gave me the support system I needed to succeed. It made me realize that I wasn't in this alone, that I could get help whether I was at work or at home. And it is contagious. I have many friends and co-workers who have become more active and are now running buddies of mine.

As a result of my new lifestyle, my children will not face many of the struggles I had to deal with in the past. They understand good food choices and moderation (which was foreign to me). I'm thankful for my wife, my workplace wellness program, and my health coaches who helped me change from an overweight, at-risk employee into a picture of health.

The CHAIRMAN. Thanks, Mr. Abernathy, for your own story.

Mrs. Mathis.

STATEMENT OF JENNIFER MATHIS, BAZELON CENTER FOR MENTAL HEALTH LAW, WASHINGTON, DC

Mrs. MATHIS. Thank you. Chairman Alexander, Ranking Member Murray, members of the committee, thank you for inviting me to testify concerning this very important issue. As Senator Murray said, I serve as director of programs at the Bazelon Center for Mental Health Law. The Center is a national non-profit organization that works to promote equal opportunities for individuals with mental disabilities in all aspects of life, from litigation, policy advocacy, training, and education.

I am also here on behalf of the Consortium for Citizens with Disabilities, or CCD, which is a coalition of national disability organizations working for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

CCD believes that wellness programs can be useful tools to promote health and well-being. In fact, the idea of early intervention is very consistent with good practices in disability service systems. We do, however, have significant concerns about the potential of some wellness programs to discriminate against individuals with disabilities if applicable laws like the Americans with Disabilities Act are not followed.

As you know, the employment rate of people with disabilities is far lower than that of any other group tracked by the Bureau of Labor Statistics, and people with disabilities have been disproportionately impacted by the economic downturn. People with disabilities tend to have employment rates of somewhere between one-third and one-half of the employment rates of people without disabilities. It's a significant problem.

Against this backdrop, we think it is important to ensure that employer-based wellness programs are implemented to promote healthy behaviors without eroding longstanding and critical workplace protections for people with disabilities. In light of the differences in understanding among different people about how the ADA interacts with the Affordable Care Act in this area, we hope, like some of our colleagues in the business community, that the

Equal Employment Opportunity Commission, or the EEOC, will soon issue guidance or regulations to clarify the ADA's application to wellness programs. Such clarification would benefit both employers and employees and afford stakeholders an opportunity to offer input about how the requirements of the ACA and the ADA should interact in the area of wellness.

CCD believes that the ADA and ACA do coexist easily in their application to wellness programs, and that the requirements of both laws can be followed at the same time. We look forward to a regulatory process that will allow the EEOC to clarify how these laws do intersect. Absent EEOC action through policymaking or litigation, we are concerned that many employees with disabilities will continue to be faced with the following predicament, which is that due to the threat of losing thousands of dollars for failing to respond to intrusive medical inquiries, many employees with disabilities are left with little choice but to disclose highly sensitive information about their disabilities, information that the ADA intended to protect from disclosure as it has nothing to do with these employees' ability to do their jobs. In some cases, information solicited is not even connected to the wellness services actually offered.

For this reason, we think it is extremely important that the EEOC has brought litigation to address what we think are some clear violations of the ADA in this context where people were punished for not answering medical questions by losing their employer's entire or nearly entire contribution to their health insurance coverage.

The cases that have been brought by the EEOC have largely been cases where it's hard to imagine how the choice that the person was presented could be considered a true voluntary choice about whether to disclose disability-related information.

The ADA's confidentiality protections are among its most important. Congress put these protections in place in the ADA based on consideration of an extensive record and a long history of intractable discrimination against people with disabilities in the workplace. It is critical for people with disabilities to maintain the privacy rights afforded to them under the ADA as they participate in wellness programs. Thank you.

[The prepared statement of Mrs. Mathis follows:]

PREPARED STATEMENT OF JENNIFER MATHIS

Chairman Alexander, Ranking Member Murray, and members of the committee: Thank you for inviting me to testify concerning this important issue. My name is Jennifer Mathis. I serve as director of Programs at the Bazelon Center for Mental Health Law, a national non-profit organization that works to promote equal opportunities for individuals with mental disabilities in all aspects of life through litigation, policy advocacy and training. I am here also on behalf of the Consortium for Citizens with Disabilities, a coalition of national disability organizations working for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

While CCD believes that wellness programs can be useful tools to promote health and well-being, we have significant concerns about their potential to discriminate against individuals with disabilities if applicable laws such as the Americans with Disabilities Act (ADA) are not followed. As you know, the employment rate of people with disabilities is far lower than that of any other group tracked by the Bureau of Labor Statistics, and people with disabilities have been disproportionately impacted by the economic downturn. Against this backdrop, we think it is important to ensure that employer-based wellness programs are implemented to promote

healthy behaviors without eroding longstanding and critical workplace protections for people with disabilities.

In light of the different understandings about the ADA's interaction with the Affordable Care Act in this area, we hope that the Equal Employment Opportunity Commission (EEOC) will soon issue guidance or regulations to clarify the ADA's application to wellness programs. Such clarification would benefit both employers and employees, and afford stakeholders an opportunity to offer input about how the requirements of the ACA and the ADA should interact in the area of wellness. Moreover, the Departments of Labor, Health and Human Services, and Treasury have left this door open, making clear in their final regulations implementing the ACA's wellness provisions that other laws such as the ADA may also apply and impose additional requirements. Employers and employees alike are eager for clarification.

CCD believes that the ADA and the ACA co-exist easily in their application to wellness programs, and that the requirements of both laws can be followed at the same time. We look forward to a regulatory process that will allow the EEOC to clarify how these laws intersect.

Absent EEOC action through policymaking or litigation, we are concerned that many employees with disabilities will continue to be faced with this predicament: due to the threat of losing thousands of dollars for refusing to respond to intrusive wellness program medical inquiries, many employees with disabilities are left with little choice but to disclose highly sensitive information about their disabilities—information that the ADA intended to protect from disclosure, as it has nothing to do with these employees' ability to do their jobs. In some cases, the information solicited is not even connected to wellness services actually offered. The ADA's confidentiality protections are among its most important; Congress put these protections in place in the ADA based on consideration of an extensive record and a long history of intractable discrimination against people with disabilities in the workplace. It is critical for people with disabilities to maintain the privacy rights afforded to them under the ADA as they participate in wellness programs.

The ADA prohibits employers from penalizing employees for failing to answer non-job related medical inquiries as part of a wellness program.[1]

The ADA prohibits discrimination on the basis of disability with regard to the "terms, conditions, and privileges of employment," 42 U.S.C. § 12112(a), including in contractual relationships with fringe benefits providers that have the effect of discriminating against employees with disabilities, *id.* at § 12112(b)(2). "Discrimination" under the ADA is defined as, *inter alia*, conducting medical examinations or inquiries of employees that are not job-related and consistent with business necessity. 42 U.S.C. § 12112(d)(4)(A).[2] There is an exception permitting "*voluntary* medical examinations, including *voluntary* medical histories, which are part of an employee health program available to employees at that work site." *Id.* at § 12112(d)(4)(B) (emphasis added); *see also EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act* (July 27, 2000) at Question 22, *http://www.eeoc.gov/policy/docs/guidance-inquiries.html* ("EEOC Guidance").

The purpose of the ADA's bar on medical inquiries that are not job-related and consistent with business necessity is to guard against discrimination and ensure that disability-related inquiries are limited to those necessary to determine whether an individual can do the job. See S. Rep. 101–116, at 39–40 (1989) ("As was abundantly clear before the committee, being identified as disabled often carries both blatant and subtle stigma. An employer's legitimate needs will be met by allowing the medical inquiries and examinations which are job-related."). As the EEOC noted in its guidance concerning disability-related inquiries of employees:

> Historically, many employers asked applicants and employees to provide information concerning their physical and/or mental condition. This information often was used to exclude and otherwise discriminate against individuals with disabilities—particularly nonvisible disabilities, such as diabetes, epilepsy, heart disease, cancer, and mental illness—despite their ability to perform the job. The ADA's provisions concerning disability-related inquiries and medical examinations reflect Congress's intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employ-

[1] The ADA also has other applications to wellness programs, including requiring reasonable modifications to requirements that individuals meet certain health targets where such requirements would deny equal opportunity based on disability. I focus, however, on penalties for failure to respond to wellness program medical inquiries since that issue has been the primary focus of attention in recent discussions.

[2] There is little dispute that the medical inquiries asked as part of wellness programs typically relate to an employee's health and not to the ability to perform job duties.

ers to ensure that individuals in the workplace can efficiently perform the essential functions of their jobs.[3]

In the absence of a statutory definition of voluntary, "we construe a statutory term in accordance with its ordinary or natural meaning." *FDIC* v. *Meyer*, 510 U.S. 471, 476 (1994) The ordinary meaning of "voluntary" is "not impelled by outside influence" and "[w]ithout valuable consideration." *Black's Law Dictionary* (9th ed. 2009). *See also Merriam Webster Dictionary* ("unconstrained by interference" and "without valuable consideration").

Since 2000, the EEOC, charged with enforcing and interpreting Title I of the ADA, has defined "voluntary" for purposes of this provision consistently with this common-sense definition. According to the agency, "voluntary" means that an employer may neither require participation nor penalize employees who do not participate.[4] Thus, medical questions that an employee is penalized for not answering are not voluntary.[5]

Indeed, the EEOC similarly interpreted a parallel provision in the Genetic Information Non-Discrimination Act (GINA). The Act prohibits covered employers from requesting, requiring or purchasing genetic information from employees, except in limited circumstances including when the employee voluntarily discloses the information as part of a wellness program.[6] In its implementing regulations, the EEOC states that the "wellness program" exception applies only where "the provision of genetic information is voluntary, meaning the covered entity neither requires the individual to provide genetic information nor penalizes those who choose not to provide it." 29 C.F.R. § 1635.8(b)(2)(i)(A). Accordingly, an employer "may not offer a financial inducement for individuals to provide genetic information." *Id.* § 1638.5(b)(2)(ii). While an employer may offer financial inducements for completion of health risk assessments that include questions about family medical history or other genetic information, the employer must make 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. *Id.*

The ACA did not silently repeal the ADA's provisions concerning medical inquiries in wellness programs.

First, it is important to note that the ACA did not supersede the ADA's requirement that non-job-related medical inquiries in wellness programs be voluntary and failure to answer not be penalized. It is well-established law that courts presume that Congress did not repeal prior laws without saying so. *See Morton* v. *Mancari*, 417 U.S. 535, 550–51 (1974) ("cardinal rule" of statutory construction that "repeals by implication are not favored"). It would be remarkable if Congress jettisoned the ADA's detailed requirements concerning medical inquiries—a cornerstone of the ADA's protections—without saying a word about this repeal in either the statute or in the legislative history.

The ADA's separate application to wellness programs was also recognized by the Departments of Labor, Health and Human Services, and Treasury in their final wellness regulations:

> As noted in section II.H later in this preamble, these final regulations are implementing *only* the provisions regarding wellness programs in the Affordable

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[3] *EEOC Guidance*, General Principles.

[4] *EEOC Guidance*, Question 22.

[5] As recognized by the Department of Health and Human Services, Department of the Treasury, and Internal Revenue Service, a penalty for failure to participate in a wellness program should be treated the same as an inducement to participate. *See, e.g., Final Rule, Incentives for Nondiscriminatory Wellness Programs in Group Health Plans*, 78 Fed. Reg. 33158, 33160 (June 3, 2013) ("References in the final regulations to a plan providing a reward include both providing a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and imposing a penalty (such as a surcharge or other financial or nonfinancial disincentive)."). Thus employees who choose to forego a financial inducement to participate are effectively penalized financially for not participating.

[6] 42 U.S.C. § 2000ff–1(b)(2). The statute allows employers to acquire genetic information "where—(A) health or genetic services are offered by the employer, including such services offered as part of a wellness program; (B) the employee provides prior, knowing, voluntary, and written authorization; (C) only the employee (or family member if the family member is receiving genetic services) and the licensed health care professional or board certified genetic counselor involved in providing such services receive individually identifiable information concerning the results of such services; and (D) any individually identifiable genetic information provided under subparagraph (C) in connection with the services provided under subparagraph (A) is only available for purposes of such services and shall not be disclosed to the employer except in aggregate terms that do not disclose the identity of specific employees." *Id.*

> Care Act. Other State and Federal laws may apply with respect to the privacy, disclosure, and confidentiality of information provided to these programs. For example . . . employers subject to the Americans with Disabilities Act of 1990 (ADA) *must comply with any applicable ADA requirements for disclosure and confidentiality of medical information and non-discrimination on the basis of disability*.[7] (emphasis added)
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> * * *
>
> Compliance with the HIPAA nondiscrimination rules (which were later amended by the Affordable Care Act), including the wellness program requirements in paragraph (f), is *not determinative of compliance with any other provision of ERISA, or any other State or Federal law, including the ADA*. This paragraph is unchanged by these final regulations and remains in effect. As stated in the preamble to the 2006 regulations, the Departments recognize that *many other laws may regulate plans and issuers in their provision of benefits to participants and beneficiaries*. These laws include, but are not limited to, the ADA, Title VII of the Civil Rights Act of 1964, Code section 105(h) and PHS Act section 2716 (prohibiting discrimination in favor of highly compensated individuals), the Genetic Information Nondiscrimination Act of 2008, the Family and Medical Leave Act, ERISA's fiduciary provisions, and State law.[8] (emphasis added)

The ACA does not address whether penalties may be imposed for failure to answer wellness program medical inquiries, and to the extent that the ACA addresses penalties generally, it speaks to whether such penalties constitute insurance discrimination, not workplace discrimination.

The ACA is not an employment discrimination statute. It does not purport to address whether wellness program penalties or other aspects of wellness programs constitute disability-based employment discrimination. Instead, the ACA prohibits disability-based discrimination in *insurance coverage*, providing that "[a] group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on" one of eight "health status-related factors," including "health status" and "disability." Public Law 111–148 (Mar. 23, 2010), § 2705(a). To comply with this non-discrimination provision, wellness programs that offer rewards for satisfying a standard based on a health status factor must meet certain conditions, including a limit on such rewards to no more than 30 percent of the cost of employee-only coverage. *Id.* §§ 2705(j)(1)(C), (j)(3).[9] Wellness programs offering rewards that are *not* based on satisfying a standard related to a health status factor—which presumably would include rewards for answering medical inquiries—comply with the non-discrimination requirement as long as participation in the program is made available to all similarly situated individuals. *Id.* §§ 2705(j)(1)(B), (j)(2).

The ACA does not conflict with the ADA's requirements concerning medical inquiries in wellness programs and both laws should be given effect.

"[W]hen two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective." *Morton* v. *Mancari*, 417 U.S. 535, 551 (1974). The ADA's provisions concerning medical inquiries and the ACA's provisions concerning wellness program penalties are clearly capable of coexistence and both must be given effect. If the ACA required penalties or rewards that were prohibited by the ADA, the two statutes would conflict. But the mere fact that the ACA provides that certain penalties do not violate its requirement concerning non-discrimination in insurance coverage does not mean that such penalties comply with the ADA or other laws.

Indeed, it is routine for two statutes that apply to the same conduct to impose independent obligations. *See, e.g., K.M.* v. *Tustin Unified School Dist.*, 725 F.3d 1088 (9th Cir. 2013) (Individuals with Disabilities Education Act (IDEA) coexists with ADA and public schools must comply with both; while public school's failure to provide word-for-word transcription service to deaf student did not violate IDEA's requirement to provide a free and appropriate public education, that did not foreclose claim that this failure violated ADA's requirement to provide student with

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[7] 78 Fed. Reg. 33158, 33165.

[8] Id. at 33168.

[9] Among other things, such programs must not be a subterfuge for discriminating based on a health status factor, and must allow reasonable alternative standards for an individual to receive the reward when a medical condition makes it unreasonably difficult or medically inadvisable for him or her to meet the standard. *Id.* § 2705(j)(3)(B), (D).

equally effective communication). *See also* Statement of Interest of the United States of America in *S.S.* v. *Springfield Public Schools*, Civ. Action No. 3:14-cv–30116, at 2, *http://www.ada.gov/briefs/springfield_ma_soi.pdf (". . . while the ADA and IDEA provide complementary protections for many students with disabilities, they are not identical in purpose or scope and impose distinct obligations on school districts in furtherance of their respective statutory mandates. . . . [the ADA] may require different or additional measures to avoid discrimination against children with disabilities than the measures that are required to comply with IDEA.").*

Where, as here, the two statutes do not even address the same issue—the ACA addresses what constitutes insurance discrimination and the ADA addresses what constitutes employment discrimination—it would be particularly inappropriate to look to the terms of the ACA to determine what constitutes a violation of the ADA. Both statutes apply to wellness programs and both impose independent obligations that do not conflict.

Thank you for the opportunity to provide testimony on this important issue. The Consortium of Citizens with Disabilities appreciates the committee's interest in this issue and stands ready to assist in any effort to secure further clarification concerning the ADA's application to wellness programs.

The CHAIRMAN. Thank you, Mrs. Mathis.

Mr. Dreiband.

STATEMENT OF ERIC S. DREIBAND, PARTNER, JONES DAY, WASHINGTON, DC

Mr. DREIBAND. Good morning, Chairman Alexander, Ranking Member Murray, and members of the committee. Thank you for affording me the privilege of testifying before you today. My name is Eric Dreiband, and I'm a partner at the law firm of Jones Day here in Washington, DC.

In 1990, Congress passed and President George H. W. Bush signed the Americans with Disabilities Act. This important civil rights law is known as the ADA, and it prohibits discrimination in employment on the basis of disability. It also authorizes employers to conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program. The law also contains a safe harbor that permits employers to implement benefit plans that are based on underwriting risk.

Congress directed the Equal Employment Opportunity Commission to enforce these protections. The Commission is also known as the EEOC, as we've heard from some of our witnesses today. And in July 2000, the EEOC stated that a wellness program is voluntary and therefore lawful as long as the employer neither requires participation nor penalizes employees who do not participate.

In 2006, the Departments of Labor and Health and Human Services and the Treasury enacted regulations under the Health Insurance Portability and Accountability Act. This law is known as HIPAA, and the 2006 HIPAA regulations authorized employers to reward employees who participate in wellness plans with financial inducements of up to 20 percent of the cost of health insurance coverage.

On January 6, 2009, the EEOC announced that it agreed with this 20 percent standard. The EEOC reasoned that "borrowing 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."

On March 6, 2009, however, the EEOC rescinded its endorsement of the HIPAA standards and said that it was continuing to

examine what level, if any, of financial inducement to participate in a wellness program would be permissible under the ADA.

In 2010, Congress passed the Patient Protection and Affordable Care Act. That law provides that a financial inducement for employee participation in wellness programs will be lawful if it does not exceed 30 percent of the cost of coverage. The law also authorizes the Secretaries of Labor, Health and Human Services, and the Treasury to increase lawful financial inducements for participation up to 50 percent of the cost of coverage.

On August 20, 2012, the U.S. Court of Appeals for the 11th Circuit rejected an Americans with Disabilities Act challenge to a wellness program that imposed a $20 charge on each bi-weekly paycheck issued to employees who refused to participate in the program. The court reasoned that the Americans with Disabilities Act's safe harbor exempted the wellness program from the ADA's prohibitions.

Next, on June 3, 2013, the Secretaries of Labor, Health and Human Services, and the Treasury issued regulations that permit employers to reward employees who participate in wellness plans by now offering financial inducements of up to 30 percent of the cost of health coverage, and as high as 50 percent for programs designed to prevent or reduce tobacco use.

In August and September 2014, the EEOC filed lawsuits that alleged that various wellness programs violated the Americans with Disabilities Act. Then in October 2014, the EEOC filed suit against Honeywell International, Inc. and alleged that Honeywell's wellness program violates the Americans with Disabilities Act even if it complies fully with the Affordable Care Act.

The Commission asserted that the 11th Circuit's decision is wrong about the ADA's safe harbor, that the safe harbor does not apply to wellness programs, and that compliance with the Affordable Care Act is not a defense to their ADA action.

In November 2014, a Federal District Court judge in Minnesota rejected the EEOC's position.

All of this leaves the public in a lurch. Protections for working people and their benefits are unclear. Employers face the threat of EEOC investigations and lawsuits even if they structure their wellness plans to comply fully with the Affordable Care Act. And after a nearly 6-year examination, the Commission has failed or refused to explain how it believes a wellness plan may be lawful.

The EEOC is flip-flopping. Its investigations and its litigation perpetuate confusion and uncertainty. None of this serves the public good. And if the executive branch of the government will not end this sorry State of affairs, the Congress should do so by enacting appropriate legislation.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Dreiband follows:]

PREPARED STATEMENT OF ERIC S. DREIBAND

I. INTRODUCTION

Good morning Chairman Alexander, Ranking Member Murray, and members of the committee. Thank you all for the privilege of testifying today. My name is Eric Dreiband, and I am a partner at the law firm Jones Day here in Washington, DC.

I previously served as the General Counsel of the U.S. Equal Employment Opportunity Commission ("EEOC" or "Commission"). The EEOC is a Federal law enforce-

ment agency that is charged with enforcing very important Federal laws against discrimination on the basis of race, color, sex, religion, national origin, age, disability, and genetic information, among others. As EEOC General Counsel, I directed the Federal Government's litigation under the Federal employment antidiscrimination laws. I also managed approximately 300 attorneys and a national litigation docket of approximately 500 cases. I was privileged to work with many public officials who dedicated their careers to serving the public, enforcing the civil rights laws, rooting out unlawful discrimination, and working to ensure that our Nation reaches the idea of equal opportunity for everyone. These individuals continue their important work. They investigate charges of discrimination. They mediate and conciliate disputes and work with individuals, unions, and employers to resolve very difficult and often painful problems. They pursue enforcement through litigation in the Federal courts, at every level up to and including the Supreme Court of the United States. And, these very able EEOC officials have the awesome power of the U.S. Government to back them up.

It is with this background that I appear here today, at your invitation, to speak about employer wellness programs.

The Americans with Disabilities Act of 1990 ("ADA") authorizes employers to conduct medical examinations and to obtain employee medical history of employees as part of wellness programs as long as participation by employees is voluntary. The Patient Protection and Affordable Care Act ("ACA") specifies that the reward for a wellness program may be up to 30 percent of the cost of coverage, with the potential for that to increase to 50 percent. Moreover, the U.S. Department of the Treasury, the U.S. Department of Labor, and the U.S. Department of Health and Human Services ("the Departments') have issued standards for wellness programs that likewise endorse the ACA's 30 and 50 percent standards, and the U.S. Court of Appeals for the Eleventh Circuit has determined that the ADA may exempt wellness plans from that law. However, compliance with the ACA may not eliminate the risk of ADA liability for employers, at least according to the U.S. Equal Employment Opportunity Commission ("EEOC" or "Commission"). Since March 2009, the Commission has declined to endorse any definition of what the ADA's "voluntary" standard means, and in a recent court case, the EEOC asserted that the decision by the Eleventh Circuit is wrong. So employers and employees throughout the United States are left with the rather bizarre situation in which the Congress and one part of the executive branch of the Government have endorsed a set of standards that it says govern wellness plans and comply with the law while the EEOC has failed or refused to explain what it will treat as a lawful "voluntary" wellness plan. The Commission's silence about this issue is perplexing, and the Congress, the EEOC, or both should clarify exactly how a wellness plan will comply with the ADA.

II. STATUTORY BACKGROUND

Congress enacted the Americans with Disabilities Act[1] in 1990. That law permits disability-related inquiries and medical examinations that are part of a "voluntary" wellness program. Specifically, the ADA states:

> "A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity."[2]

On the other hand, Section 102(d)(4)(B) of the ADA states that employers

> "may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."[3]

Section 501(c)(2) authorizes employers to establish, sponsor, observe, and administer

> "the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law."[4]

The Health Insurance Portability and Accountability Act ("HIPAA"), enacted in 1997, did not specifically address wellness programs but rather included a general prohibition against provisions in employer group health plans that discriminated

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[1] See 42 U.S.C. § 12101 et seq.
[2] 42 U.S.C. § 12112(d)(4)(A).
[3] 42 U.S.C. § 12112(d)(4)(B).
[4] 42 U.S.C. § 12201(c)(2). This is sometimes referred to as a "safe harbor" provision.

against employees with respect to their plan participation based on factors such as health status, medical conditions, or claims experience.[5] In 2006, in response to employer concerns that wellness programs could be deemed to violate these HIPAA nondiscrimination standards, the Departments issued regulations that exempted wellness programs from the HIPAA nondiscrimination rules if they met certain requirements.[6] Those regulations authorized employers to offer financial inducements to participate in wellness plans of up to 20 percent of the cost of coverage.[7]

In 2010, Congress passed and the President signed the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act or the "ACA." With respect to wellness programs, the ACA provides that

> "[a] reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan." [8]

Specifically, the ACA states that the reward for a wellness program

> "shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled . . . The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate." [9]

III. EEOC AND JUDICIAL POSITIONS ON WELLNESS PROGRAMS

According to the EEOC, a wellness program is "voluntary" if the employer "neither requires participation nor penalizes employees who do not participate." [10] In a letter dated January 6, 2009—2 weeks before President George W. Bush left office—the EEOC's Office of Legal Counsel announced that a wellness plan would be "voluntary" (and therefore lawful) if "the inducement to participate" does not

> "exceed 20 percent of the cost of employee only or employee and dependent coverage under the plan, consistent with regulations promulgated pursuant to the Health Insurance Portability and Accountability Act." [11]

The EEOC explained that

> "[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." [12]

On March 6, 2009, however, the EEOC rescinded this statement and announced that it was "continuing to examine what level, if any, of financial inducement to participate in a wellness program would be permissible under the ADA." [13] EEOC's "examination" has continued for nearly 6 years, and when this examination will conclude, if it ever does, is unclear. On January 18, 2013, EEOC reiterated that

> "[t]he EEOC has not taken a position on whether and to what extent a reward amounts to a requirement to participate, or whether withholding of the reward from non-participants constitutes a penalty, thus rendering the program involuntary." [14]

EEOC held a hearing about wellness plans on May 8, 2013,[15] and more than 18 months after that hearing, the EEOC apparently is still "continuing to examine" its position about wellness plans.

The courts and the Departments are not waiting for the EEOC. On August 20, 2012, the U.S. Court of Appeals for the Eleventh Circuit rejected a challenge to a wellness program that imposed a $20 charge on each biweekly paycheck issued to employees who enrolled in the employer's group health insurance plan and refused

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[5] See ERISA Section 702(a), 29 U.S.C. § 1182(a).
[6] See Department of Labor Regulations, 29 C.F.R. § 2590.702(f).
[7] See 78 Fed. Reg. 33158.
[8] 42 U.S.C. § 300gg–4(j)(3)(A).
[9] *Id.*
[10] See *http://www.eeoc.gov/policy/docs/guidance-inquiries.html*.
[11] See EEOC Opinion Letter, Jan. 6, 2009 at 2, rescinded on March 6, 2009, *http://pdfserver.amlaw.com/cc/WellnessEEOC2009.pdf*.
[12] *Id.*
[13] See *http://www.eeoc.gov/eeoc/foia/letters/2009/ada__disability__medexam__healthrisk.html*.
[14] See *http://www.eeoc.gov/eeoc/foia/letters/2013/ada__wellness__programs.html*.
[15] See *http://www.eeoc.gov/eeoc/newsroom/release/5–8–13.cfm; http://www.eeoc.gov/eeoc/meetings/5–8–13/index.cfm*.

to participate in the employee wellness program.[16] The court reasoned that a "safe harbor" contained in the ADA permits employers to make disability-related inquiries and give medical examinations to observe the terms of a "bona fide benefit plan," and because the $20 charge was a "term" of the employer's health plan, the plan was "bona fide" and therefore lawful.[17]

On June 3, 2013, the Departments issued rules that permit employers to

> "reward employees who participate in wellness plans, including plans that involve health-related questionnaires or biometric tests, by offering financial inducements up to 30 percent of the cost of health coverage and as high as 50 percent for "programs designed to prevent or reduce tobacco use." [18]

IV. EEOC LAWSUITS AGAINST EMPLOYERS

Even though EEOC has yet to provide employers guidance on what is "voluntary," the agency has filed multiple lawsuits against employers for their wellness programs. In August 2014, the EEOC filed a lawsuit that alleged that a wellness program violated the ADA.[19] In its complaint, the EEOC alleged that Orion Energy Systems' wellness program was not "voluntary" and therefore violated ADA Section 102(d)(4)(A).[20] In its Answer, Orion denied that its wellness program violated the ADA and, listed as some of its affirmative defenses, stated that the program is a "bona fide benefit plan" and that the medical examinations were "voluntary." [21]

One month later, in September 2014, the EEOC brought suit against Flambeau, Inc., a plastics manufacturer, alleging that the employer violated the ADA because its wellness program

> "required that employees submit to biometric testing and a 'health risk assessment,' or face cancellation of medical insurance, unspecified 'disciplinary action' for failing to attend the scheduled testing, and a requirement to pay the full premium in order to stay covered." [22]

In its Answer, Flambeau stated that its program was a "bona fide benefit plan" and that the biometric testing and health risk assessments were voluntary and thus denied that its program violated the ADA.[23]

In its third lawsuit, filed in October 2014, the EEOC pursued a different strategy by seeking a temporary restraining order and preliminary injunction against Honeywell International, Inc. for its wellness program.[24] The EEOC alleged that Honeywell's wellness program is an involuntary medical examination that was not job-related and therefore in violation of the ADA.[25] Honeywell argued that its wellness program: (1) is covered under the ADA's safe harbor provision (Section 501(c)(2)); and (2) comports with the ADA's voluntary wellness program provision (Section 102(d)(4)(B)).[26] Moreover, Honeywell maintained that the ACA illustrated "Congress' express approval of surcharges used in conjunction with wellness programs. [27] In response, EEOC argued that Honeywell's wellness program was not "voluntary,"

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[16] See *Seff* v. *Broward County*, 691 F.3d 1221 (11th Cir. 2012).

[17] *Id.* at 1223–24.

[18] See *http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=26880&AgencyId=8&DocumentType=2*.

[19] See *http://www.eeoc.gov//eeoc/newsroom/release/8–20–14.cfm?renderforprint=1*. See also *EEOC* v. *Orion Energy Systems, Inc.*, Case No. 14–1019 (E.D. Wis. Complaint filed Aug. 20, 2014).

[20] Plaintiff EEOC's Complaint at 5–6, *EEOC* v. *Orion Energy Systems, Inc.*, Case No. 14–1019 (E.D. Wis. filed Aug. 20, 2014). The EEOC also alleges that Orion retaliated against an employee for her objections against the wellness program, and that Orion "interfered, coerced, and intimidated" the employee in violation of the ADA. Id. at 6–7.

[21] Defendant Orion Energy Systems' Answer at 4–5, *EEOC* v. *Orion Energy Systems, Inc.*, Case No. 14–1019 (E.D. Wis. filed Oct. 16, 2014).

[22] See *http://www.eeoc.gov//eeoc/newsroom/release/10–1–14b.cfm?renderforprint=1*. See also Plaintiff EEOC's Complaint, *EEOC* v. *Flambeau, Inc.*, Case No. 14–638 (W.D. Wis. filed Sept. 30, 2014).

[23] Defendant Flambeau's Answer, *EEOC* v. *Flambeau, Inc.*, Case No. 14–638 (W.D. Wis. filed Nov. 24, 2014).

[24] *EEOC* v. *Honeywell Int'l, Inc.*, Civil No. 14–4517 (D. Minn. Oct. 27, 2014).

[25] *EEOC* v. *Honeywell Int'l, Inc.*, Civil No. 14–4517, 2014 U.S. Dist. LEXIS 157945, at *11 (D. Minn. Nov. 6, 2014). Under the program, Honeywell employees that choose to participate agree to undergo biometric testing and become eligible for an HSA in which Honeywell contributes $250 to $1,500 to qualified employees in a certain salary range. *Id.* at *2–4. Those employees who choose not to participate in the program do not qualify for a company-sponsored HSA and must also pay a $500 surcharge. *Id.* at *4.

[26] *Id.* at *13.

[27] *Id.* **at *14.**

the Eleventh Circuit's decision is wrong, and that "compliance with HIPAA and the ACA are not defenses to the ADA.[28]

The court in *Honeywell* ultimately rejected the EEOC's position and declined to issue a preliminary injunction. The court determined that the EEOC failed to establish the threat of irreparable harm and that additional factors weighed against an injunction.[29] The court also noted that

> "great uncertainty persists in regard to how the ACA, ADA and other Federal statutes such as [the Genetic Information Nondiscrimination Act] are intended to interact,"

but that

> "[s]hould this matter proceed on the merits, the Court will have the opportunity to consider both parties' arguments after the benefit of discovery in order to determine whether Honeywell's wellness program violates the ADA and/or GINA."[30]

V. CONCLUSION

All of this raises many questions. It is too soon to tell whether other courts will agree with the Eleventh Circuit. The EEOC does not agree and said so explicitly in the *Honeywell* case. Whether the EEOC will agree with the Affordable Care Act's standards remains to be seen. Employers that design and implement wellness plans that comply with the ACA may be unpleasantly surprised to find that the EEOC asserts that such plans may violate the ADA. And, the EEOC's continued and lengthy "examination" of wellness programs calls into question the EEOC's ability to enforce the law, to put the matter mildly.

And so the public is left with a sorry state of affairs when it comes to wellness plans. The EEOC's flip-flopping, ongoing and seemingly never ending "examination," and litigation perpetuate confusion and uncertainty. The public is also left with a government that has spent more than half a decade trying to figure out the meaning of the word "voluntary." None of this serves the public good, and if the executive branch of the Government will not end this regulatory mess, the Congress should do so by enacting appropriate legislation.

The CHAIRMAN. Thank you, Mr. Dreiband.

There should be time for all the Senators to ask questions before we go to vote.

Mr. Dreiband, what is the solution to the confusion you described?

Mr. DREIBAND. The solution I think would come in one of two forms. One, either the EEOC should articulate a public position about how employer wellness plans can comply with the Americans with Disabilities Act, and they would do that either by endorsing the 11th Circuit's decision and saying that the safe harbor does apply to these wellness programs, or as part of that the EEOC could define finally what the statute means to be voluntary under the Americans with Disabilities Act.

Alternatively, the Congress could enact legislation.

The Commission has been looking at this now for nearly 6 years and has not articulated any standard at all, and that's what has created, I think, the problems that at least the public is facing now.

The CHAIRMAN. In your opinion, does the law, the Affordable Care Act and the regulations that have been adopted pursuant to it, provide employers with sufficient certainty to be able to establish wellness programs? What I'm trying to get at is are the regulations under the Affordable Care Act appropriate or do they need to be changed?

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[28] Plaintiff EEOC's Memorandum in Support of EEOC's Application for Temporary Restraining Order and an Expedited Preliminary Injunction at 13–19, *EEOC* v. *Honeywell Int'l, Inc.*, Civil No. 14–4517, 2014 U.S. Dist. LEXIS 157945 (D. Minn. filed Oct. 27, 2014).

[29] *Honeywell Int'l, Inc.*, Civil No. 14–4517, 2014 U.S. Dist. LEXIS 157945, at *5–10.

[30] *Id.* at *13–15. This paper does not address the issues involving Genetic Information Nondiscrimination Act ("GINA").

Mr. DREIBAND. I think both the Affordable Care Act, the statute that Congress passed in 2010 and the regulations that the executive branch passed, the Secretaries of Labor, Treasury, and Health and Human Services passed, they clearly authorize employer wellness programs that include financial inducements of up to 30 percent of the cost of coverage.

The problem I think is that the EEOC in 2009 endorsed the then-existing HIPAA standard of 20 percent, rescinded that standard and hasn't replaced it with anything, and now takes the position that compliance with the Affordable Care Act says nothing about compliance with the Americans with Disabilities Act.

The CHAIRMAN. There is a specific provision in the Affordable Care Act itself that employers must provide a reasonable alternative to employees who can't complete the employer's standard requirement. Is that correct?

Mr. DREIBAND. Yes.

The CHAIRMAN. And that would be designed to help deal with the question of a disabled employee. Is that right?

Mr. DREIBAND. Yes, and I think the Americans with Disabilities Act would require employers to provide reasonable accommodations to individuals with disabilities if they are participating in a program, sure.

The CHAIRMAN. Dr. Loveman, you represent, I think you said, the Business Roundtable employs 40 million people.

Mr. LOVEMAN. Yes, Mr. Chairman.

The CHAIRMAN. And their large number of wellness programs. Do you see the confusion described by Mr. Dreiband as discouraging implementation of wellness programs or not making much difference, and do you have any comment about what we need to do, if anything, to reduce the confusion?

Mr. LOVEMAN. Yes and yes, Mr. Chairman. First, up until the action of the EEOC recently, I don't believe that any of my colleagues and their companies' wellness programs were discouraged much at all. But this recent action did give pause to all of us that what we consider to be a very well-intentioned intervention to improve the health of our employees and provide higher quality outcomes for them was threatened by the ambiguity that the counselor has just described in his remarks.

With respect to the regulations more broadly, these programs are evolving rather dynamically, and by that I mean the early stages of these programs were largely diagnostic in nature. They said a man my age ought to have certain types of tests and ought to try to appeal to certain parameters of health in his own care.

Once many people and a company have achieved those levels, the next step is how do we encourage people to actually improve their health rather than simply know what they ought to do to improve their health, and there are burdens and regulations among the different departments that impede the ability to reward the actual improvement of health rather than the diagnostic efforts taken to understand how one might improve one's health. So I think that is an area where we need additional clarification and help.

The CHAIRMAN. Thank you.

The same committee that recommended the Americans with Disabilities Act is the committee that also recommended the Afford-

able Care Act, and the guardians of rights for disabled Americans had no greater champion than Senator Harkin and other members of this committee. Yet, it was very clear in the Affordable Care Act that the committee wanted employers to be able to provide incentives up to 30 percent for leading a healthy lifestyle, with a specific exemption for dealing with those employees who couldn't reach that standard.

So let me invite the five witnesses. My time is about up. If you have specific suggestions—I know, for example, Dr. Baase, you've written a lot about this—for how to resolve the confusion that Mr. Dreiband described, or Ms. Mathis, if you have specific suggestions, we'd like to have them. And if you could send them to us when the hearing is over, they would be helpful to us in evaluating whether the regulation which appears to be coming from the EEOC is sufficient or whether we need to take some action in the Congress.

Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman. I know Senator Harkin well. I've worked with him forever. I know for a fact that he would never push legislation that went against ADA. It was his heart and soul.

But, Ms. Mathis, I want to thank you. You've had a chance to hear some of the answers so far, and I really appreciate your coming here today to make sure we do have a good perspective on the role of the Americans with Disabilities Act and the work of the Equal Employment Opportunity Commission as they relate to these employer wellness programs.

Can you respond a little bit to what you've heard and share why worker protections and civil rights are so important as we enact this?

Mrs. MATHIS. Sure. One of the interesting things about Senator Harkin is he recently at a hearing described, I think, what his vision of what happened in the Affordable Care Act was with respect to wellness programs and how it interacted with the ADA and how he understood that you can have wellness programs and you can have penalties in wellness programs without being inconsistent with the ADA, and that like GINA, like the Genetic Information Non-discrimination Act, there is a separate rule under GINA and under the ADA about when you're asking questions—disability-related questions under the ADA, genetic information questions under GINA—that you just can't penalize people for not answering those particular questions. That's all.

Senator Harkin said I think it's totally consistent. You can have wellness programs. This is the one thing that you have to be careful about, and I think that piece about answering disability-related questions, that has been really at the heart of the ADA. That has been one of the most important pieces of the ADA for people with disabilities.

I work in the area of mental health. It is true—I wish it weren't, but it is true that for many people having certain diagnoses, having a diagnosis of schizophrenia, of schizo-affective disorder, in many cases bipolar disorder, that is a death sentence if an employer discovers that.

That is why Congress deliberately and very carefully created these rules around what kinds of inquiries can be asked of people

with disabilities on the job and very specifically said you can ask only things that are job-related and consistent with business necessity. Nobody, I think, is claiming that these types of questions on a health risk assessment are job related. It's not about your ability to do the job. It's about your health.

The one exception to that rule is that you can ask, but only if it's part of an employee health program that is voluntary. That's really the issue. And as Mr. Dreiband said, one of the issues for the EEOC is to define what is voluntary, and the EEOC has always said that if there's a penalty attached, that's not voluntary. But I think there's room to further clarify what the EEOC means by that.

The other issue is, aside from confidentiality, what Senator Alexander referred to, the penalties for not meeting a health target. There, the ACA has a reasonable alternative standard built in. If it's medically inadvisable or unreasonably difficult for somebody to meet that kind of health target because of a disability, they have to be given a reasonable alternative standard, and the Health and Treasury rules, the DOL rules address that, and I think that is very consistent with the ADA's reasonable accommodation requirement. I think the agencies will interpret those two sets of rules consistently under the two separate statutes.

The issue has really been, I think, more challenging to understand the interaction with the medical inquiries and the penalties on the medical inquiries.

Senator MURRAY. Thank you. I really appreciate your response.

I just have a few seconds left. I wanted to ask Dr. Grossman, if a company is going to implement a wellness program, how best can they go about deciding how to pick intervention strategies and prevention approaches?

Dr. GROSSMAN. Thank you, Senator Murray. That's a great question. There are a number of resources out there that are very valuable for companies to use. The National Business Group on Health, for example, has an excellent resource available for companies. The CDC, the Centers for Disease Control, and also the Community Preventive Services Task Force issues something called the Community Guide which has a series of recommendations out there that I think is also useful.

There are ample resources currently available for employers. They tend to be perhaps more geared toward large employers, the large-size rather than small- or medium-size employers.

Senator MURRAY. OK. Thank you very much.

Dr. GROSSMAN. Thank you.

The CHAIRMAN. Thank you, Senator Murray.

Senator Isakson.

STATEMENT OF SENATOR ISAKSON

Senator ISAKSON. Dr. Loveman, what kind of doctor are you?

Mr. LOVEMAN. A Ph.D. in economics, unlike my colleagues, not a science according to many.

[Laughter.]

Senator ISAKSON. The other type of health care.

And you're with the Business Roundtable?

Mr. LOVEMAN. That's correct. I chair the Committee on Health Reform.

Senator ISAKSON. We have a number of companies in Georgia—IBM, Santa Fe, Georgia Regents, a number of people like that—who have received recognition for the programs they have put in for wellness that have reduced the impact of their cost. Does the Business Roundtable promote that sort of thing?

Mr. LOVEMAN. Yes, sir, we do. We have tremendous support among the companies that are members for these types of programs.

Senator ISAKSON. I have a question for you and Dr. Baase. Is it Baase?

Dr. BAASE. Yes, that's right.

Senator ISAKSON. And Dr. Grossman.

I believe the only way a business or an employer can effectively and positively impact the cost to their employees and to the company of health care is through disease management and wellness. Is that correct? Under the current environmental and regulatory and statutory requirements under which you operate, the only real way a company can impact positively the cost of health care it provides to its employees and its share of that cost is through robust wellness and disease management programs.

Dr. BAASE. I think both of those, wellness programs and disease management, are important strategies. But I do think companies have other things that they can do. I mean, they work on the methodology of their benefit plan design, they work on collaboration with the providers of care to seek innovation and mechanisms of even payment reform and other things that can be done to improve quality of care, cost of care, or the health of people.

I do think that, in our strategy, for example, we have pillars of prevention, quality and effectiveness of care, health system management and advocacy. I think that employers can engage the communities within which they operate and their plan partners, as well as what they can do within their own company.

We also work with the communities as part of multi-stakeholder efforts in a collective impact model. So the communities within which we operate have health improvement strategies, and an employer can become part of those as well.

So I'm agreeing with you that wellness programs and disease management programs are critical actions, but I do think there's a bigger horizon than that that complements them.

Senator ISAKSON. Dr. Grossman.

Dr. GROSSMAN. Yes, I agree that I think wellness programs have a lot to do with reducing risk factors for chronic disease in the future for employees. In the short term, health care costs by employers largely stem from two main factors, utilization and the price of those services. And whether or not they're fully insured or self-insured as employers, they should be working with either their plans or their administrative service organizations to really focus on utilization and price as also a very key mechanism for addressing cost.

Senator ISAKSON. On the utilization issue, though, Senator Warren and I have a care coordination provision we've proposed for Medicare where we reimburse for care coordination, because there

are so many people getting health care from different sources. There is redundant and fee-for-service costs, which drives the cost up.

Do you all in any way in any of your companies promote care coordination within the coverage?

Dr. GROSSMAN. At Group Health, care coordination is taken extremely seriously because we see ourselves as managing the total cost of care, and clearly care coordination is a major factor in stemming utilization of care, and we take that very seriously.

Dr. BAASE. Activities around the patient-centered medical home and care coordination are certainly the types of partnerships that we are also involved in our communities and with our plans.

Senator ISAKSON. I think for us as policymakers, Mr. Chairman, I'm told—and I can't remember the exact percentage, but the two largest contributors to the cost of Medicare are hypertension and diabetes, both of which are substantially preventable with good care management, good wellness programs, and good involvement of the patients. So we really ought to promote those as much as we can to help reduce the cost of that, not just to the individual but to the taxpayer.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Isakson.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman and Ranking Member Murray.

I'm really encouraged to learn of the innovative programs that the witnesses have talked about today, and I too want to share some cutting-edge activity that's happening in the State of Wisconsin, my home State.

In particular, I wanted to highlight a program created by one of the largest American printing companies, Quad/Graphics, which is located in Sussex, WI. Back in 1991, Quad/Graphics established a fully integrated patient-centered medical home called QuadMed for its now 22,000 employees nationwide. QuadMed includes a team of salaried health professionals who bring primary care and wellness services right onsite for its employees. The employees have access to these onsite clinics, fitness centers, rehab facilities, pharmacists, nutritionists, as well as an electronic medical record and a digital patient portal.

Now it's a national model for employer-based care, and QuadMed has not only improved employee satisfaction and productivity through this model, but the program also has an economic benefit, an economic incentive. The program provides a $3.70 return for every $1.00 invested up front.

So I believe it's critical that we continue to support and advance similar initiatives to help improve our Nation's health.

Dr. Grossman, I'm encouraged to hear that your health system, Group Health Cooperative, works with other organizations in your community. In fact, you've highlighted in your testimony some of the leadership roles that they've taken.

Another example in my home State of Wisconsin is in La Crosse, where we too have an innovative integrated health system called

Gundersen Health System that not only has its own wellness program for employees but also partners with local businesses to offer onsite clinics, and with school districts and convenience stores, actually, in the La Crosse area to offer healthy food products and healthy meals.

So I'd like to hear you talk a little bit more about Group Health Cooperative's initiatives to advance wellness in your whole community and beyond, beyond your own employees, and how this helps improve population health in the patients that you serve.

Dr. GROSSMAN. Thanks very much, Senator Baldwin. It's exciting to hear about those great activities in Wisconsin, which is clearly a great State, another leader in health care.

Group Health as a non-profit actually has a substantial commitment to the benefit and to the health of the community and engages in a variety of activities to help promote health in the broader community statewide. And recently, through some recent reforms occurring in our own State, we're developing what's called Accountable Communities of Health where communities are actually coming together to work together—hospitals, employers, health departments, and health care providers—to actually set targets and goals for geographically defined communities in order to advance the health of the communities and the citizens living in those areas.

That is something that Group Health is very much planning to participate in and be actively engaged in those efforts. We have sponsored for many years a number of health promotion activities among non-profit providers that actually extend the reach, and certainly have endorsed other efforts by groups that are providing those services, such as YMCA, for example, through their diabetes prevention program, or through the Cascade Bicycle Club that actually has gotten thousands and thousands of Washingtonians, including myself, to get engaged in riding.

So Group Health sees the engagement with the broader community as being a very key part of the work that you're describing.

Senator BALDWIN. Great.

Dr. Loveman, I'm wondering if you can discuss how your work with employees that may not be able to fully participate in some aspects of Caesars' wellness program, maybe due to an injury or an illness, how do you maintain the engagement and morale of those who may not see measureable results as quickly as some of their peers do?

Mr. LOVEMAN. Senator Baldwin, that's a great question. Let me take, for example, our facility in New Orleans, LA, a city known for many things great but not always the greatest of health outcomes.

We have onsite care providers in our facility in New Orleans, and so employees literally every day are meeting with well nurses and other members of the professional medical staff to talk about specific things that could happen in their lives that would make them and their family members healthier.

So while there may be special circumstances in certain instances such as those described by Ms. Mathis that would preclude the employee from taking a more traditional route in these wellness programs, it's the obligation of those who work for us in these in-

stances to customize what's available to them in a way that suits them, and the stories that I hear coming back to us that follow from these interventions are really quite remarkable.

The CHAIRMAN. Thank you, Senator Baldwin.

Votes have not started yet, so there should be sufficient time for the remaining three Senators to take their questions, and we'll stick to 5 minutes.

Senator Scott.

STATEMENT OF SENATOR SCOTT

Senator SCOTT. Thank you, Mr. Chairman.

Mr. Dreiband, just a couple of questions for you. In October, the EEOC filed suit against Honeywell to stop the company from offering financial rewards to employees who participate in biometric screening as part of the company's wellness program.

As this committee is well aware, in light of provisions in the ACA specifically allowing employers to reward employees for participation in wellness programs, many employers across the country have adopted these programs, programs they believe to be compliant with current law, including HIPAA and the ACA. While the EEOC said it would issue guidance on this topic and employers have sought official guidance, the Commission has yet to do so. Lawsuits that target compliant programs, especially in the absence of guidance from the EEOC, serve to confuse employers and employees and may reduce participation in these beneficial wellness programs.

Given these facts, do you believe the EEOC was justified in filing suit against an employer over its wellness plan when Congress has encouraged the programs and the EEOC has yet to make clear how it views the law, particularly when the agency went into court a mere 7 business days after a complaint was filed against Honeywell with the agency?

Mr. DREIBAND. I don't know all of the evidence that the EEOC had when it sued Honeywell. I'm not involved in that case. What I will say is I think it's patently unfair for the U.S. Government to endorse a standard, as the EEOC did in January 2009, and then to rescind it and spend 6 years doing nothing about replacing that standard, and then threatening companies and individuals with potential liability of the sort that the EEOC has the power to bring in Federal District Court. I think the Commission should articulate a standard and then put the public on notice of what it is if it's going to litigate and enforce the law.

Senator SCOTT. A followup question, perhaps a more difficult question. From your perspective and in your opinion, why has the EEOC targeted these effective health care programs through the legal system rather than simply issuing the guidance that so many of these companies are desperately seeking? And as a former general counsel, would you say that the EEOC is using effectively their resources when they have, I think, 70,000, 75,000 complaints outstanding?

Mr. DREIBAND. Yes. I don't know why the EEOC has not been able to figure out in 6 years what the statute means by the word "voluntary." I mean, what we're talking about here is a single word in a statute, one word, "voluntary." It's one thing not to articulate

a standard. That's one thing. But it's another thing, as has happened here, to say that the Commission is going to endorse a standard, as it did, for Congress to pass a law that essentially expands and encourages employers to use these wellness plans, and EEOC to sit on its hands for 6 years and then sue people. To me, it's a question of fundamental due process of law, and I don't think it's fair at all, and I don't know why they're doing it. I suppose you could ask them.

I do think there are legitimate concerns about coercing people into participating in wellness plans, and that may be motivating the Commission. But they can certainly articulate a position publicly about what they think is permissible under the Americans with Disabilities Act.

Senator SCOTT. Thank you. Six years is plenty of time.

Let me ask Dr. Loveman, who brought up a very important point. I'm a Charlestonian, South Carolina. You were talking about the good food in New Orleans. I would recommend that you come to the Nation's best tourist destination to really experience good food. Unfortunately, the result of good food sometimes is an expanding waistline. Please do not use mine as an example.

However, I would ask you that according to the recent National Business Group Health Survey, 95 percent of employers offered a health risk assessment biometric screening or other wellness program in 2014, and nearly three-quarters of employers use incentives to encourage employees to participate in these programs.

Do you believe that the benefits of these programs would be as profound if employers were not able to somehow encourage participation in the programs?

Mr. LOVEMAN. Senator, I think you're on a very, very important point. It's been my experience with our 70,000 folks that you cannot encourage recalcitrant participants in this sort of activity without the use of some sort of an incentive. So when these incentives are first applied—for example, for biometric screening—you observe a high uptake among those you would naturally expect to do so, those who are very active in the management of their own health, and then you find others who are a little bit slower to come along.

As the incentive becomes more and more appealing, finally someone who has not otherwise been called to action decides, you know what, I'm going to go get that biometric screening; what's the harm with checking my blood pressure and my glucose level? And if the company is going to discount my premiums by $75 every 2 weeks, that seems like a very appealing opportunity, and they do, and the remarkable benefit that accrues to their family to some degree, as you've heard from Mr. Abernathy's testimony, it is a very, very encouraging thing.

Senator SCOTT. Absolutely. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Scott.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thank you very much, and we appreciate the panel's testimony and willingness to be here today. I

know I missed a good bit of the testimony, but I'll try to focus just on maybe one or two issues. It may only be one.

First of all, I wanted to start with the predicate, which is I think all of us can agree that we've made substantial strides in making sure that wellness is part of our health care strategy. It used to be that we would laud wellness programs and say that's a good example over there by that company or that particular program, and we would not then engage in strategies that would make sure that everyone was doing something on wellness. We just thought it was the exception rather than the rule. I think we're getting closer to making it much more of a standard.

I know that there are some instances where there can be a concern that wellness programs may go too far and may infringe on other basic rights that people have. I know that, Ms. Mathis, you said—I'm just looking at your written testimony on page 6. You say the Affordable Care Act does not conflict with the ADA's requirements concerning medical inquiries in wellness programs, and both laws should be given effect.

I would ask you to explain what you mean by that, and I know you've walked through some of this in your own testimony here today, but I know this is the written testimony.

Mrs. MATHIS. Sure.

Senator CASEY. That's question No. 1. Question No. 2 is can you give me an example of a wellness program which has reached or has achieved an accommodation that is contemplated by the ADA? That was one of the greatest achievements in recent American history, that the ADA said that an employer should have reasonable accommodations for that employee, not any accommodation, not any accommodation that people would develop, but reasonable accommodations. I think we can have both a very strong ADA as well as a strong and well-implemented Affordable Care Act.

Mrs. MATHIS. That's right. So let me say something about the second question first, actually. I don't know—I haven't seen on-the-ground examples of what kinds of accommodations have been offered as reasonable alternative standards for people who can't meet a health target because of a disability, or it's unreasonably difficult or medically inadvisable. Those are the ACA standards. The ADA standard is reasonable accommodation to provide equal opportunity.

But I do know that that part seems to be working out well. I think that the regulations that were issued implementing that piece of the ACA really are closely in line with how people would see reasonable accommodation as working. So I think the idea and the examples in those regulations are things like if you can't meet maybe a body mass index standard, that you have an alternative of going to a gym or getting a subsidy for a gym or doing an education class or different things that will in other ways help you achieve better health outcomes while taking into account your disability and the real limitations that it may impose that may make it hard to meet the health standard.

So I think those things seem to be operating fairly well, in sync the ACA and the ADA.

I think with the medical inquiries, all of the language in the ACA about the 30 percent penalties and all that, that's all about

meeting health targets. That's all about satisfying a health standard. It does not talk about medical inquiries particularly. The ACA has no language about medical inquiries. That's not what Congress seemed to be thinking about.

There is sort of a catch-all provision. Basically, the ACA has this non-discrimination in insurance provision that says, "well, you can't discriminate based on health status in insurance", except that here is sort of how we think it should work in wellness programs, and you can have these penalties, and we think it doesn't discriminate based on health factors. It doesn't violate the ACA's health non-discrimination requirement if you do these things. That's all it says. It doesn't say that we're saying that this then complies with—if you follow these rules for the ACA, that it complies with every other law, and there are often situations where multiple laws will apply, and all this does is say that to the extent that you're not, that you're imposing penalties that are not related to a health target, that it's just about penalties for medical inquiries, for example, that they're not going to violate this health insurance non-discrimination provision.

Does that mean that they don't violate the ADA, which has entirely different sets of concerns, which is about workplace discrimination? Confidentiality of information is not a concern that Congress was addressing in the ACA and the health insurance discrimination provisions.

So, yes, I think the ADA applies at the same time, and there are many instances in the world where you will have two laws that apply to the same situation, and they may require some different things.

I think here it's not really all that onerous. We have a rule in GINA——

The CHAIRMAN. Mrs. Mathis, I think we need to go to the next Senator.

Mrs. MATHIS. Sure.

The CHAIRMAN. If you would wrap up your comments. Please go ahead.

Senator CASEY. I'll make sure you get something in writing as well.

Mrs. MATHIS. Thank you.

Senator CASEY. Thank you.

The CHAIRMAN. Thank you, Senator Casey.

Senator Mikulski.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you, Mr. Chairman.

You know, when we passed the Affordable Care Act, I was most excited. There were many things I was excited about. But the two things that I was most excited about, in addition to dealing with preexisting conditions and improving access, was wellness workplace opportunities, as well as a medical home so that you could have coordinated services and, again, perhaps nutrition, mental health counseling, and a variety of things.

So we looked at the whole person, and we dealt with the issues. What I was looking forward to in terms of a hearing like this was to really be able to talk about what has been the impact of passing

the law, has it done any good in large workplaces and employers, what are the best practices that we're learning now to motivate people. Motivation is not an easy issue. And then how a regular guy like Mr. Abernathy found homes and happiness in broccoli and better eating. I don't know if it is broccoli.

So I'm very frustrated to hear that we're now arguing over EEOC giving regs and rules and so on. I would hope we could encourage the EEOC to really publish its guidance and to do it in a full public comment so all could testify, acknowledging challenges like in the mental health area. But we've got to get on with this because what I'm concerned about, given the uncertainty of the law, the wellness programs are going to pull back or go minimalist.

Are my concerns, Dr. Baase, well-founded?

Dr. BAASE. I appreciate your comments very much. I think, as my statement was about the imperative for our country, that we have employers involved, and we've got to find a way to make it most effective. I think people are utilizing the evidence that's out there, just as Dr. Grossman indicated, and that evidence base has been improving, appreciating the work of the CDC and the Guide to Community Preventive Services that's out there.

We've still got opportunities for improvement in wellness programs and health promotion programs. But certainly what we want to do is strengthen those efforts and not have people pull back. So I endorse what you're saying.

Senator MIKULSKI. But in the absence of EEOC clarity, do you think employers will pull back?

Dr. BAASE. I think it clearly has a dampening effect where people feel like they don't need to be dealing with this kind of risk situation.

Senator MIKULSKI. That they don't want to get into it.

Dr. BAASE. Right.

Senator MIKULSKI. So tell me, though, Dow has really been one of the leaders in workplace wellness programs. What have you found has been the impact? And also, what do you think have been some of the best practices to really motivate people?

Dr. BAASE. We have been very successful. Since our baseline in 2004, we have improved the health of our people worldwide, a 28 percent reduction in high risk and a 15 percent increase in low risk of our population, and our employees highly value the services and the programs of the wellness and health promotion effort. They see it as a huge benefit to them, and they participate at high levels, approaching 90 percent on a global basis.

Senator MIKULSKI. Wow.

Dr. BAASE. And we find that it has an impact to us across the board in our corporate priorities. It has an impact in terms of our improvement in safety, because healthier people have better safety outcomes. We know that our ability to attract and retain talent is impacted by the nature of the culture that we have in the company that highly supports health and healthy living, and our ability to get the best performance out of the investment we have in our human beings in the company.

So it's something where we've had remarkable success, and the culture of the company is a huge multiplier. But I also made an additional comment that we work with the communities within

which we're operating and partnering with them, and one of the Senators made a comment about diabetes. We're currently involved in a community effort, the Diabetes Prevention Program and creating system change in our community.

There's a great number of things that can be done by an employer to advance health, and we need to strengthen and support that.

Senator MIKULSKI. Thank you, and I know my time is up.

The CHAIRMAN. Thank you, Senator Mikulski.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. I'm glad, Dr. Baase, that you mentioned the Diabetes Prevention Program. This is something that, with Senator Lugar, I put into the ACA, that we should be promoting this. This is a CDC program. CDC and NIH together piloted it to YMCAs, one in Indianapolis and one in St. Paul. Hence, Franken-Lugar.

I know, Senator Isakson—I'm sorry I wasn't here for a lot of this; I was in the Energy Committee—this works. What it is, it's 16 weeks of physical training and nutritional training to people who have pre-diabetes. I think, Dr. Grossman, you mentioned the Diabetes Prevention Program in answering a question.

What it did was, pre-diabetes is people who have this blood—they're about to become diabetic if they don't do something about it. Longitudinally, it reduced the chances of becoming diabetic in the next 5 years by 59 percent. So much of the cost of care in this country goes to people's chronic conditions, and diabetes is one of the No. 1 chronic conditions.

So, just to all of you, how can we, through workplace programs, encourage, without violating people's privacy and rights and all that kind of stuff, just encourage people, encourage employers and encourage employees to take advantage of this, get this covered maybe by the employer or by the employer's insurance company? I've been doing some pilots in the VA. I have a bill to get Medicare to pay for this, because the return on investment is tremendous.

Any ideas on this at all in terms of workplace?

Mr. LOVEMAN. If I may, Senator, employer wellness programs, because these large private employers are self-insured, we have tremendous discretion as to what we cover and the circumstances under which we seek to support our employees.

For example, in our case, the fact that the care centers are in the same facility where our employees work, particularly since some of them work unusual hours, they're surrounded by access to information, support, encouragement, collegiality around this question. They're able to really manage the preventive steps around pre-diabetic care very thoughtfully.

I think these programs provide—in addition to the incentive structures that we've described and tools for access to better care and more high value-added interventions—all the right tools to do what your legislation has proposed, and I think you're seeing that across the programs that my colleagues on this panel have been promulgating.

Senator FRANKEN. Dr. Grossman.

Dr. GROSSMAN. Yes, I agree with you that the Diabetes Prevention Program was a solid piece of evidence. It's been used both by the U.S. Preventive Services Task Force and the Community Guide in their reviews in understanding what works, particularly around weight management, but specifically around this area that you're speaking of.

I think we know at Group Health that we have a number of employers who have expressed interest in this specific program, and we supported that through coverage and through providing that service. It does require an engaged employer to get participation going.

It's not the sole solution. It's part of a spectrum of solutions, and actually part of potentially a menu of choices that employees could have to actually engage in better managing their weight, and also their physical activity, because what we know about effective weight management is that it's not just about dieting, it's also about maintaining an effective activity program.

Senator FRANKEN. Again, this is 16 weeks of physical and nutritional training.

Dr. GROSSMAN. Absolutely. Correct.

Senator FRANKEN. I had a meeting with the Deputy HHS Secretary, with the YMCAs, and United Healthcare, a big Minnesota company, and the executive from United Healthcare said we will just cover this for any of our people who are pre-diabetic. We'll pay for it because we will save $4 for every dollar we spend.

Dr. GROSSMAN. Yes.

Senator FRANKEN. I'm just a champion for that, you see.

I'm done.

[Laughter.]

The CHAIRMAN. Thank you, Senator Franken.

Senator Murray, do you have any concluding remarks?

Senator MURRAY. Thank you very much for this hearing.

I agree with Senator Mikulski. One of our goals that has sort of been forgotten in health care is to make sure that people are healthier because it does wonders for them, obviously, but it also makes sure that we are helping to control the cost of health care for this country, which is extremely important. As a government that supplies health care through Medicare and Medicaid and through a lot of services, as well as to businesses who see the rising costs of health care, it's important to them.

I think it's really important that EEOC get the rules out, working with the other agencies to make sure that they have the accommodations as described by Ms. Mathis that will assure that all people are protected, but that we don't put a stop to doing this. So I hope those come out very soon, and I share with her her concern that they get those out.

But once those rules come out—and I'm assured, actually, that they will be out very shortly—we need all the businesses that are doing the great job that many of you are and the organizations that are doing this, to take a look at them and get comments back so that we can get the final issues ruled and keep moving in this really important direction for our country.

The CHAIRMAN. Thank you, Senator Murray.

Thank you to the witnesses. Some of you have come a long way, and we appreciate that very much. You provided very helpful testimony. I think you can hear that the law demonstrates there's a strong bipartisan interest in encouraging employer wellness plans, and I think you've heard also that if things are discouraging that, such as uncertainty in the law and the regulations, we'd like to clear that up as quickly as possible.

So I would invite you, again, if you have additional thoughts about how to improve regulations that exist, how to reduce uncertainty, we'd like to have it.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

Our next hearing on health care will be February 10th. It will be on the rise of diseases that are preventable by vaccines. For example, in Disneyland and the West Coast, there's beginning to be a measles outbreak, and it has spread into other parts of the Western United States. Unlike Ebola, for which there is no vaccine—and that captured the attention of the whole world, particularly this country—we do have a vaccine for measles, yet we have an outbreak of measles. So we're going to take a look at what's happening with diseases that are preventable by vaccines and why do we have a rise of those diseases.

Thank you for being here.

The committee will stand adjourned.

[Additional Material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF JUDITH L. LICHTMAN, SENIOR ADVISOR, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES

Chairman Alexander, Ranking Member Murray, members of the committee, my name is Judith Lichtman, and I am senior advisor at the National Partnership for Women & Families. Thank you for the opportunity to offer recommendations on ensuring nondiscrimination in employer wellness programs, to be considered today in conjunction with the committee's hearing.

The National Partnership is a non-profit, nonpartisan advocacy organization with more than 40 years of experience promoting fairness in the workplace, access to quality health care and policies that help women and men meet the competing demands of work and family. Since our creation as the Women's Legal Defense Fund in 1971, we have fought for every significant advance for equal opportunity in the workplace, and we continue to advocate for meaningful safeguards that prevent discrimination against women and families.

I. ENSURING NONDISCRIMINATION IN WELLNESS PROGRAMS REQUIRES CAREFUL ANALYSIS

The National Partnership represents women and families across the country. As health care purchasers, consumers and decisionmakers for themselves and their families, women are keenly interested in wellness and prevention of illness. Employer wellness programs—if designed and implemented properly—can potentially offer women and their families an avenue for improving and maintaining their health, and lower costs for the employer.[1]

A well-designed, voluntary wellness program should be individually tailored and focused on the health and well-being of each employee. Employers should take into account personal circumstances, including family caregiving responsibilities or multiple jobs, that may make it difficult for employees, particularly women, to participate in wellness programs that take place outside of normal work hours. Employers should look to accredited wellness programs as guides. These programs offer true benefits that can help women achieve their wellness goals by providing activities at a time and location that fits the time constraints associated with their obligations at home and in the workplace. While there may be benefits of "participatory" wellness programs that seek to improve employee health across the board, we continue to be concerned by outcomes-based or punitive wellness programs that operate to shift costs to employees and have not been scientifically proven to promote improved health.

There is scant evidence showing that punitive programs tying health insurance premiums to health outcomes actually improve employee health.[2] These wellness programs often require a one-size-fits-all approach that does not address individual employees' life circumstances and wellness needs; these programs often utilize biometrics that are not always adequate measures of health. Such programs enable employers to reduce their health care costs under the guise of wellness promotion by merely shifting those costs to employees that they deem to be most unhealthy. This practice is akin to medical underwriting, the practice of determining an employee's health insurance premium on the basis of certain health information.[3] Employers must not be permitted to utilize employer wellness programs as a subterfuge for discriminatory cost-shifting that decreases affordability and access to health insurance for those who need it most.

As described in further detail below, punitive wellness programs implicate employment nondiscrimination statutes if they disproportionately penalize women, racial minorities, older workers and other protected classes. Wellness programs that impose punitive measures or that grant so-called "rewards" in the form of lower insurance premiums to some employees but not to others could run afoul of anti-dis-

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[1] Mercedes Carnethon, et al., Work site wellness programs for cardiovascular disease prevention: a policy statement from the American Heart Association. American Heart Association Advocacy Coordinating Committee; Council on Epidemiology and Prevention; Council on the Kidney in Cardiovascular Disease; and Council on Nutrition, Physical Activity and Metabolism (2009).

[2] *See* V. Paul-Ebhohimhen & A. Avenell, *Systematic review of the use of financial incentives in treatments for obesity and overweight*, 9 Obesity Reviews 355–67 (Oct. 23, 2007); Kevin G. Volpp, David A. Asch, Robert Galvin & George Loewenstein, *Redesigning Employee Health Incentives—Lessons from Behavioral Economics*, 365 N. Engl. J. Med. 388–90 (Aug. 4, 2011).

[3] Nat'l Women's Law Center, Nowhere to Turn: How the Individual Health Insurance Market Fails Women 7 (2008), *http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf*.

crimination laws if they have a disparate impact on members of a protected group. Women, racial minorities and older workers are more likely to pay increased costs associated with punitive wellness programs. These groups are more likely to experience significant health disparities and are particularly vulnerable to chronic illnesses, and as a result they may face greater difficulty satisfying employer-defined benchmarks.[4]

Although the Patient Protection and Affordable Care Act (ACA) permits employers to implement wellness programs, it also sets important nondiscrimination standards for such programs that are intended to safeguard civil rights. Section 1557 of the ACA prohibits discrimination on the basis of sex, race, color, national origin and disability by health programs receiving Federal funds or by any entity established under Title I of the Act.[5] Section 1557 incorporates and applies numerous civil rights laws, such as Title VI of the Civil Rights Act of 1964,[6] Title IX of the Education Amendments of 1972,[7] the Age Discrimination Act of 1975,[8] and Section 504 of the Rehabilitation Act of 1973,[9] to Federal health programs and entities. Section 1557's incorporation of these key protections mandates that health plans receiving Federal premium tax credits are bound by existing civil rights law applicable to other federally assisted programs.[10]

Additional provisions of the ACA require insurance companies to cover all applicants and to offer enrollees the same rates regardless of pre-existing conditions or sex.[11] For example, the law prohibits gender rating.[12] The law also limits medical underwriting.[13] Allowing employer wellness programs to raise costs for protected groups contravenes the purpose of these provisions, which endeavor to ensure equal and affordable access to everyone, regardless of sex, pre-existing conditions, or other status.

Similarly, punitive programs that impose fees or withhold financial rewards for failing to meet certain health benchmarks carry the risk of disproportionately impacting groups protected under Title VII of the Civil Rights Act of 1964,[14] the Americans with Disability Act (ADA),[15] Age Discrimination in Employment Act (ADEA),[16] the Equal Pay Act,[17] Genetic Information Nondiscrimination Act,[18] and the Health Insurance Portability and Accountability Act (HIPAA),[19] among other laws. These laws prohibit discrimination on the basis of sex, race, national origin, age and other protected categories.

The Equal Employment Opportunity Commission (EEOC) is charged with ensuring that employer wellness programs do not operate as a subterfuge for unlawful discrimination. The EEOC, which is tasked with enforcing employment nondiscrimination laws, serves a critically important role in ensuring equal opportunity for workers in the United States. The EEOC is the first place workers who have experienced discrimination must go to pursue their claims and it provides invaluable assistance to workers in filing charges, investigating claims and mediating and attempting to conciliate the charges that the agency deems meritorious. The agency also litigates specific charges, authorizes workers to file complaints in court and participates as *amicus curiae* in key courts of appeals cases. Through enforcement, guidance, outreach, education, technical assistance and advice to other Federal agencies, the EEOC has an opportunity to ensure that employers comply with nondiscrimination laws, such as those set forth in the ACA and in other civil rights

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[4] Alina Salganicoff, et al., Women and Health Care: A National Profile, Kaiser Family Foundation (July 2005), *https://kaiserfamilyfoundation.files.wordpress.com/2013/01/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey.pdf*; Leandris C. Liburd, *Looking Through a Glass, Darkly: EliminatingHealth Disparities*, 3 Preventing Chronic Disease (July 2006), available at: *http://www.cdc.gov/pcd/issues/2006/jul/pdf/05_0209.pdf*.

[5] 42 U.S.C. § 18116.

[6] 42 U.S.C. §§ 2000d *et seq*.

[7] 20 U.S.C. §§ 1681 *et seq*.

[8] 42 U.S.C. §§ 6101 *et seq*.

[9] 29 U.S.C. §§ 794 *et seq*.

[10] Rene Bowser, *The Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice*, 10 Hastings Race & Poverty L. J. 69, 91 (2013).

[11] 42 U.S.C. § 300gg.

[12] *Id.*

[13] 42 U.S.C. §§ 300gg-4(a) to (b).

[14] 42 U.S.C. §§ 2000e *et seq*.

[15] 42 U.S.C. §§ 12101–12213.

[16] 29 U.S.C. §§ 621–634.

[17] 29 U.S.C. § 206(D) (2006).

[18] 42 U.S.C. § 2000ff–6(a)(1).

[19] 42 U.S.C. §§ 300g, 1181 *et seq*., 1320d *et seq*.

statutes, and follow best practices in the design and implementation of wellness programs.

II. STATUTES IMPLICATED IN NONDISCRIMINATION ANALYSIS

A. Title VII of the Civil Rights Act of 1964: Employer wellness programs that impose disproportionate penalties or disproportionately deny rewards on the basis of sex, race or national origin may violate Title VII of the Civil Rights Act of 1964.[20]

Title VII prohibits discrimination with respect to "compensation, terms, conditions, or privileges of employment."[21] An employer may violate title VII by treating members of a protected class differently than others (i.e., disparate treatment discrimination).[22] In order to state a disparate treatment claim, the plaintiff must show that the employer treats some people less favorably than others on the basis of plaintiff's membership in a protected group.[23] Critical to a disparate treatment claim is the employer's discriminatory motive, although this motive can be inferred in some circumstances.[24]

An employer may also violate Title VII by utilizing a facially neutral employment practice if it has an adverse impact upon persons of a protected group (i.e., disparate impact discrimination).[25] In order to State a *prima facie* disparate impact claim, the plaintiff must point to a specific policy or practice that has an adverse impact on the basis of race, sex, or other protected characteristics.[26] The Supreme Court, in a case addressing an employer's unequal provision of health insurance coverage, held that "health insurance and other fringe benefits are compensation, terms, conditions, or privileges of employment" under title VII.[27] Charging increased fees or denying rewards for failure to meet certain biometrics could be subject to a disparate impact challenge under the title VII framework.

For the purposes of an adverse action under a title VII framework, financial rewards and penalties can operate as flip sides of the same coin. A wellness program that offers a "reward" to those who meet certain benchmarks may constitute an adverse action for those who do not qualify for the reward, just in the same way that a penalty may constitute an adverse action for those who are required to pay a higher cost. Although the language of the wellness program might refer to a "penalty" or "reward," the effect is the same: to shift the employer's health insurance costs disproportionately to protected groups.

Some wellness programs offer voluntary activities and benefits for all employees, such as flex-time for exercise or reduced gym memberships, geared toward encouraging employees to improve and maintain their health. But wellness programs that tie rewards or fees to health benchmarks could be expected to have an adverse impact on women and racial minorities, because women and racial minorities are more likely to experience the most serious health disparities. For example, women are more likely than men to have medical conditions such as obesity[28] and arthritis.[29]

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[20] 42 U.S.C. §§ 2000e *et seq*.

[21] 42 U.S.C. § 2000e–2(a)(1).

[22] *See, e.g., Dep't of Water & Power* v. *Manhart*, 435 U.S. 702, 711 (1978) (holding that the plaintiffs established a *prima facie* case of discrimination by demonstrating that an employer charged all female employees higher retirement fund premiums than it charged to males).

[23] *Id.*

[24] *Int'l Bhd. of Teamsters* v. *United States*, 431 U.S. 324, 335 n. 15 (1977).

[25] *See Griggs* v. *Duke Power Co.*, 401 U.S. 424, 429–33 (1971).

[26] *Id*. at 432 (explaining that the complainant must show that an employer has a "particular employment practice" that causes a disparate impact).

[27] *Newport News Shipbuilding and Dry Dock Co.* v. *E.E.O.C.*, 462 U.S. 669, 682 (1983).

[28] Cynthia L. Ogden et al., Nat'l Center for Health Statistics, Obesity Among Adults in the United States—No Statistically Significant Change Since 2003–2004 1 (2007), *available at*: *http://www.cdc.gov/nchs/data/databriefs/db01.pdf*.

[29] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Weekly Report: Prevalence of Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation—United States, 2010–2012 (Nov. 8, 2013), *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6244a1.htm*.

Racial minorities are more likely to face heart disease,[30] obesity[31] or diabetes.[32] Over one-third of African-American women over age 45 report fair or poor health, and almost 30 percent have diabetes.[33] African-American women also suffer from the greatest obesity rates.[34] African-Americans have the highest mortality rate of any racial and ethnic group for all cancers combined.[35] They are twice as likely to be diagnosed with diabetes compared to non-Hispanic whites,[36] and also 40 percent more likely to have high blood pressure.[37] Hispanic adults are 1.7 times more likely than non-Hispanic white adults to have been diagnosed with diabetes,[38] and twice as likely to have certain types of cancer compared to non-Hispanic white Americans.[39] Even when income, health insurance and access to care are accounted for, disparities remain.[40] While well-designed, nondiscriminatory wellness programs that seek to combat these conditions and improve employees' health may be a worthy endeavor, wellness programs that merely seek to shift costs depending on health benchmarks may run afoul of the law.

Employers have encountered difficulty in attempting to justify a wellness program that disparately impacts a protected group. If a plaintiff is able to show that the employer's wellness program adversely impacts a protected group, the employer must demonstrate that the policy is "consistent with business necessity."[41] The employer must show that the program is "necessary to the safe and efficient operation of the business"[42] and "of great importance to job performance."[43] Proof of "mere rationality" is not enough.[44] The policy is not a business necessity "if an alternative practice better effectuates its intended purpose or is equally effective but less discriminatory."[45]

Although issues of economy can be considered, courts have concluded that cost savings alone cannot justify a policy or practice that results in a disparate impact.[46] The employer would likely encounter difficulty demonstrating that any cost savings associated with wellness programs are "necessary to the safe and efficient operation of the business,"[47] particularly when there is scant evidence establishing that wellness programs have resulted in measurably improved health outcomes for employees.[48] Although reducing health care costs is arguably a factor a court might consider, the employer would most likely need to show that there was no other solution to lowering costs that did not result in a disparate impact. Linking financial

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[30] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Weekly Report: Prevalence of Heart Disease—United States, 2005, Table 1 (Feb. 16, 2007), *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5606a2.htm*.

[31] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Weekly Report: Differences in Prevalence of Obesity Among Black, White, and Hispanic Adults—United States, 2006–2008 (July 17, 2009), *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5827a2.htm*.

[32] Ctrs. for Disease Control and Prevention, Age-Adjusted Incidence of Diagnosed Diabetes per 1,000 Population Aged 18–79 Years, by Race/Ethnicity, United States, 1997–2011, *http://www.cdc.gov/diabetes/statistics/incidence/fig6.htm* (last visited Jan. 28, 2015).

[33] *See* Salganicoff, et al., *supra* note 4.

[34] *Id.*

[35] U.S. Dep't of Health & Human Services, Office of Minority Health, Cancer and African Americans, *http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=16* (last accessed Jan. 28, 2015).

[36] U.S. Dep't of Health & Human Services, Office of Minority Health, Diabetes and African Americans, *http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=18* (last accessed Jan. 28, 2015).

[37] U.S. Dep't of Health & Human Services, Office of Minority Health, Heart Disease and African Americans, *http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19* (last accessed Jan. 28, 2015).

[38] U.S. Dep't of Health & Human Services, Office of Minority Health, Diabetes and Hispanic Americans, *http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63* (last accessed Jan. 28, 2015).

[39] U.S. Dep't of Health & Human Services, Office of Minority Health, Cancer and Hispanic Americans, *http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlID=54&ID=3323* (last accessed Jan. 28, 2015).

[40] Ctrs. for Disease Control & Prevention, Health Disparities and Inequalities Report—United States, 2013, Summary, *available at*: *http://www.cdc.gov/mmwr/pdf/other/su6203.pdf*.

[41] Civil Rights Act of 1991 § 105(a), 42 U.S.C. § 2000e–2(k)(1)(A)(i).

[42] *Ricci* v. *DeStefano*, 557 U.S. 557, 623 n. 3 (2009) (citing *Robinson* v. *Lorillard Corp.*, 444 F.2d 791, 798 (4th Cir. 1971)).

[43] *Williams* v. *Colorado Springs, Colo., Sch. Dist. No. 11*, 641 F.2d 835, 841 (10th Cir. 1981).

[44] *Jones* v. *Lee Way Motor Freight, Inc.*, 431 F.2d 245, 249 (10th Cir.), *cert. denied*, 401 U.S. 954 (1970).

[45] *Ricci*, 557 U.S. at 635 (quoting *Robinson*, 444 F.2d at 798, n. 7).

[46] *Robinson*, 444 F.2d 791, 799, n.8; *U.S.* v. *N. L. Industries, Inc.*, 479 F.2d 354 (8th Cir. 1973); *Johnson* v. *Pike Corp. of America*, 332 F. Supp. 490 (C.D. Cal. 1971).

[47] *Ricci*, 557 U.S. at 623 n. 3 (2009) (citing *Robinson*, 444 F.2d at 798 (4th Cir. 1971)).

[48] *See supra* note 2.

rewards to biometrics or other standards that may not correlate to underlying health and adopting wellness programs that disproportionately harm members of a protected group runs contrary to the spirit and the letter of title VII.

B. The Americans with Disabilities Act: Wellness programs that disproportionately impose penalties or deny rewards to people with disabilities may violate the Americans with Disabilities Act (ADA).

The ADA prohibits employment discrimination on the basis of disability and limits an employer's ability to make disability-related inquiries and to require medical examinations.[49] Generally, the examination or inquiry must be made on a post-offer basis for employment and either be "job-related and consistent with business necessity," or a voluntary medical examination, as "part of an employee health program available to employees at that work site."[50]

Wellness plans and health risk assessments may be prohibited under the ADA's "no medical exams or inquiries" provision if they are not voluntary.[51] The level of inducement, or more specifically, the value of the incentive for taking the health risk assessment, may impact whether the medical examination or inquiry is truly voluntary.[52] Financial penalties for failure to meet health criteria also can have a disparate impact on individuals with disabilities. For example, wellness programs run afoul of the ADA if they penalize employees who fail to have normal blood glucose or cholesterol levels, who fall within a certain range of weight or blood pressure, or who cannot participate in a walking or other exercise program due to a disability. In short, a wellness program that requires inappropriate disability-related inquiries, offers reduced benefits, or carries financial penalties for individuals with disabilities can subject an employer to liability under the ADA.

C. The Genetic Information Nondiscrimination Act: Wellness plans that involve genetic information or testing can run afoul of the Genetic Information Nondiscrimination Act (GINA).

GINA restricts an employer's ability to inquire about family health history or other "genetic information" as part of a program of wellness incentives under a group health plan.[53] In connection with any group health plan or health insurer, GINA prohibits the covered entity from increasing premiums or contribution amounts based on genetic information; requesting or requiring an individual or family member to undergo a genetic test; and requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for "underwriting purposes."[54] Employers must ensure that wellness programs and any associated financial incentives or penalties comply with GINA and its implementing regulations.[55] The regulations and the EEOC's June 24, 2011 opinion letter clarify that GINA prohibits employers from offering financial inducements to encourage employees to provide genetic information as part of a wellness program.[56]

D. The Age Discrimination in Employment Act: Wellness programs that disproportionately impose penalties or deny rewards to older workers may violate the Age Discrimination in Employment Act (ADEA).

The ADEA prohibits discrimination against persons over the age of 40.[57] In pertinent part, the ADEA makes it illegal for an employer to . . . discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age."[58] The statute specifically prohibits "the reduction of the rate of an employee's benefit accrual, because of age."[59] An increase to a health insurance premium could constitute an adverse action under

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[49] 42 U.S.C. §§ 12101 *et seq*.
[50] 42 U.S.C. § 12112(d); *see also Watson* v. *City of Miami Beach*, 177 F.3d 932, 935 (11th Cir. 1999); *Tice* v. *Centre Area Transp. Authority*, 247 F.3d 506, 514 n. 7 (3d Cir. 2001).
[51] *See* Equal Employment Opportunity Comm'n, ADA Enforcement Guidance: Preemployment Disability-Related Questions and Medical Examinations, *http://www.eeoc.gov/policy/docs/medfin5.pdf*.
[52] *Id.*
[53] 42 U.S.C. §§ 2000ff–1 to 2000ff–11.
[54] 42 U.S.C. § 1320d–9.
[55] 29 C.F.R. § 1635.8.
[56] 29 C.F.R. § 1635.8(b)(2)(ii).
[57] 29 U.S.C. §§ 621 *et seq*.
[58] 29 U.S.C. § 623.
[59] Age Discrimination in Employment Act, 29 U.S.C.A. § 623(i)(1)(A).

the ADEA, and an employer cannot discriminate against older workers in the provision of that benefit.

As under Title VII, an ADEA plaintiff may proceed under a theory of disparate treatment or disparate impact.[60] If the plaintiff has evidence that the employer *intended* to discriminate against older workers through a wellness program, the plaintiff may proceed with a claim of disparate *treatment*. An employer may also violate the ADEA by utilizing a facially neutral employment policy or practice that has an adverse *impact* on older workers. When an employee identifies an employment practice that causes a disparate impact,[61] the employer must show that a "reasonable factor other than age" motivated the policy.[62] Under the ADEA's implementing regulations, a "reasonable factor other than age" is a non-age factor that is,

> "objectively reasonable when viewed from the position of a prudent employer mindful of its responsibilities under the ADEA . . .[63] Factors a court could consider when determining whether the policy is reasonable include: the extent to which the factor is "related to the employer's business purpose," whether the factor was administered "fairly and accurately"

and the employer considered the impact on older workers and the extent of the harm suffered.[64]

A wellness program may violate the ADEA if it has a disparate impact on older employees, who are more likely to suffer from a range of chronic conditions (some, if not all of which also would qualify as disabilities under the Americans with Disabilities Act of 1990[65] and the Rehabilitation Act of 1973,[66] both as amended). Studies have shown that obesity,[67] hypertension,[68] high cholesterol[69] and low bone density,[70] as well as more serious conditions such as diabetes,[71] heart disease[72] and arthritis[73] are strongly correlated with age. Obesity is far more prevalent among the elderly than the general population.[74] Almost 75 percent of individuals aged 65 and over have at least one chronic illness,[75] and at least 50 percent have two chronic illnesses.[76] Thus wellness programs that penalize employees for failing to satisfy certain biometric benchmarks might be expected to disproportionately impact older workers.

As detailed below,[77] there is little reliable evidence that punitive wellness programs do more than shift costs to employees. Thus, a court could find that there is insufficient evidence to establish a defense to a disparate impact claim. Indeed, the factors laid out in the EEOC's regulations weigh against these programs.[78] There is little evidence that a wellness program is "related to the employer's business purpose."[79] Punitive wellness programs that penalize older workers whether directly, or indirectly through unattainable employee incentives, should not be

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[60] *Smith* v. *City of Jackson*, 544 U.S. 228, 240 (2005).
[61] *Meacham* v. *Knolls Atomic Power Lab.*, 554 U.S. 84, 100 (2008).
[62] *Id.* at 93–98; 29 C.F.R. § 1625.7.
[63] 29 C.F.R. § 1625.7(e)(1).
[64] 29 C.F.R. § 1625.7(e)(2).
[65] 42 U.S.C. §§ 12101 *et seq*.
[66] 29 U.S.C. §§ 701 *et seq*.
[67] Ctrs. for Disease Control and Prevention, Morbidity and Mortality Report: Vital Signs: State-Specific Obesity Prevalence Among Adults—United States, 2009 (Aug. 3, 2010), *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm59e0803a1.htm*.
[68] Ctrs. for Disease Control and Prevention, High Blood Pressure Facts, *http://www.cdc.gov/bloodpressure/facts.htm* (last visited Jan. 28, 2015).
[69] Ctrs. for Disease Control and Prevention, High Blood Cholesterol: Conditions, *http://www.cdc.gov/cholesterol/conditions.htm* (last visited Jan. 28, 2015).
[70] U.S. Dep't of Health & Human Services, Office of the Surgeon General, Bone Health and Osteoporosis: A Report of the Surgeon General, Ch. 4, Oct. 14, 2004, *available at http://www.ncbi.nlm.nih.gov/books/NBK45513/*.
[71] U.S. Dep't of Health & Human Services, Office of Women's Health, Diabetes Factsheet, *http://womenshealth.gov/publications/our-publications/fact-sheet/diabetes.html*.
[72] U.S. Dep't of Health & Human Services, Nat'l Heart, Lung & Blood Inst., Who Is at Risk for Heart Disease?, *http://www.nhlbi.nih.gov/health/health-topics/topics/hdw/atrisk.html*.
[73] Ctrs. for Disease Control and Prevention, Arthritis: The Nation's Most Common Cause of Disability, *http://www.cdc.gov/chronicdisease/resources/publications/aag/arthritis.htm*.
[74] Ctrs. for Disease Control and Prevention, Older Persons' Health, *http://www.cdc.gov/nchs/fastats/older-american-health.htm* (last visited Jan. 28, 2015).
[75] E. Calkins, et al. New Ways to Care for Older People: Building Systems Based on Evidence (1999).
[76] L.P. Fried, LP & J.M. Guralnik, *Disability in older adults: evidence regarding significance, etiology, and risk,* J. 45 Am. Geriatric Soc. 92–100 (1997).
[77] *See supra* note 2.
[78] 29 C.F.R. § 1625.7(e)(2).
[79] § 1625.7(e)(2)(i).

deemed to be administered "fairly and accurately."[80] Under the last factor—harm to the employee—it is clear that if a wellness program imposes a financial penalty, this can significantly reduce an employee's earnings.[81] As such, the ADEA protects against wellness programs that disproportionately penalize older workers.

The ADEA prohibits employers that offer health care benefits to their employees from discriminating against older workers by refusing to cover them or by reducing their benefits because of their age. However, an employer may be permitted under the ADEA to reduce benefits of older workers as long as the same amount of money is *spent* on older workers as is spent on younger workers.[82] Yet there are several ways that a wellness program might not be sheltered by this defense provided by the ADEA. First, the exception is only available to employers when "justified by significant cost consideration."[83] Second, in the context of a contributory health plan, wherein the employer and employee both contribute to the cost of the premium, the employer may increase the employee's premium contribution as the employee ages, but the *proportion* that the employee pays cannot be higher than the proportion paid by younger employees.[84] Thus, an employer would run afoul of the ADEA if the proportion of older workers' contributions increases as a result of financial penalties or increased premiums associated with wellness programs.

E. Equal Pay Act: Wellness plans that impose financial penalties can run afoul of the Equal Pay Act, which requires that women and men are compensated equally for equal work.[85]

The Department of Labor's regulations implementing the Equal Pay Act make clear that equal wages include fringe benefits.[86] The EEOC also has recognized that the Equal Pay Act requires equal compensation for not only salaries and bonuses, but also employment benefits.[87] Indeed, courts have awarded lost benefits in Equal Pay Act cases.[88] Thus, an employer wellness program could run afoul of the Equal Pay Act if it penalizes employees by granting different benefit levels to women and men with the same or similar work duties.

F. The Health Insurance Portability and Accountability Act (HIPAA): Wellness plans that discriminate in health coverage based on health factors can run afoul of the Health Insurance Portability and Accountability Act.[89]

HIPAA prohibits discrimination in participation, eligibility, premiums and contributions for health coverage[90] based on factors like health status, medical condition, medical history and genetic information.[91] The Departments of Treasury, Labor, and Health and Human Services are expected to issue a final regulation implementing HIPAA's nondiscrimination provisions in the near future. The proposed rule sets certain parameters for employer wellness programs. For example, wellness programs must be made available to all similarly situated employees. The proposed rule states that wellness programs must be reasonably designed to promote health or prevent disease. The proposed rule also states that wellness programs must provide a reasonable alternative to a health-based standard for individuals for whom it is unreasonably difficult or medically inadvisable to meet the initial standard.

III. THE EEOC'S IMPORTANT ROLE IN EVALUATING WELLNESS PROGRAMS' PUNISHMENTS AND REWARDS

The EEOC has a responsibility to investigate and, where appropriate, develop systemic and impact litigation to protect the most vulnerable workers, including low-wage workers who would be impacted by wellness program cost-shifting measures

[80] § 1625.7(e)(2)(ii).
[81] § 1625.7(e)(2)(v).
[82] 29 U.S.C. § 623(f)(2)(b).
[83] 29 C.F.R. § 1625.10(a)(1).
[84] *Id.*
[85] 29 U.S.C. § 206(D)(1).
[86] 29 C.F.R. § 1620.10.
[87] Equal Employment Opportunity Comm'n, Equal Pay/Compensation Discrimination, *http://www.eeoc.gov/laws/types/equalcompensation.cfm* (last visited Jan. 28, 2015).
[88] *See, e.g., Meadows* v. *Ford Motor Co.*, 510 F.2d 939 (6th Cir.1975), *cert. denied*, 425 U.S. 998 (1976); *Grove* v. *Frostburg Nat. Bank*, 549 F. Supp. 922, 946 (D. Md. 1982).
[89] 26 U.S.C. § 9802; 29 U.S.C. § 1182; 42 U.S.C. § 300gg-1.
[90] 26 C.F.R. § 54.9802-1(g); 29 CFR 2590.702(g); 45 C.F.R. § 146.121(g).
[91] United States Dep't of Labor, Frequently Asked Questions: The HIPAA Nondiscrimination Requirements, *http://www.dol.gov/ebsa/faqs/faq__hipaa__ND.html* (last accessed Jan. 28, 2015).

that penalize protected groups. Investigators and litigators should be trained to identify red-flags. In addition to identifying programs that unlawfully raise insurance premiums for vulnerable employees, investigators must also pay particular attention to programs that purportedly offer "rewards" to participating employees but result in fewer employees participating in the employer-provided health insurance. Employees who receive "rewards" are better able to utilize the employer's health benefits, while those who do not participate in wellness programs and do not receive these "rewards" may no longer be able to afford health insurance.

The EEOC's efforts are particularly important in light of the fact that there is little data supporting employer wellness programs that try to change employee behavior by raising insurance premiums or tying rewards to health outcomes. There is scant—if any—empirical evidence that monetary rewards can result in sustained weight loss.[92] Crucially, there is no independently evaluated research demonstrating that linking the cost of employer-sponsored insurance to certain biometrics has an impact on health outcomes.[93]

For example, biometric markers are overwhelmingly common in wellness programs generally. According to a recent survey, 90 percent of companies that have outcomes-based wellness programs use a weight-related standard and 75 percent use blood pressure, cholesterol and tobacco use.[94] However, requiring all employees to meet biometric markers such as BMI, blood pressure and cholesterol is not reasonably related to improving employees' health, particularly when the same standards are applied indiscriminately to all employees. These biometrics are influenced by a range of genetic and environmental determinants that do not affect all employees equally and are largely out of an individual's control.[95] BMI, in particular, is not an accurate assessment of health, as it is designed as a measure of public health risk, not as a marker for individual goals.[96] Penalizing all individuals with a BMI or body weight over a certain number ignores the science that shows that many individuals who are not overweight nevertheless have a high BMI, and, conversely, that many overweight people are in good health and whose blood pressure and cholesterol are in the healthy range.[97]

In addition, whether because of genetic or environmental factors, some chronic conditions do not significantly improve over time. For example, there is extensive scientific evidence indicating that employers cannot expect their employees to lose large amounts of weight and maintain significant weight loss over time, even with intensive treatment options.[98] There is also strong scientific research showing that individuals can improve their health by taking small steps toward weight loss.[99] Yet an employee who took such a step—for instance, lowering her BMI from 35 to 32, where the employer's benchmark is set at 30—would not escape a penalty under a punitive wellness program when there is one BMI benchmark required for all employees.

Some punitive wellness programs charge employees higher health insurance premiums simply for failing to reach certain benchmarks. Safeway's "Healthy Measures" program, for example, tests participating employees' tobacco use, weight, blood

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[92] V. Paul-Ebhohimhen & A. Avenell, *Systematic review of the use of financial incentives in treatments for obesity and overweight*, 9 Obesity Reviews 355–67 (Oct. 23, 2007).

[93] Kevin G. Volpp, David A. Asch, Robert Galvin & George Loewenstein, *Redesigning Employee Health Incentives—Lessons from Behavioral Economics*, 365 N. Engl. J. Med. 388–90 (Aug. 4, 2011).

[94] Health Enhancement Research Org., et al., Fact Sheet: Statistics About Workplace Wellness (July 2012), *http://hero-health.org/wp-content/uploads/2014/03/FactSheet__wellness-stats__FINAL_071512.pdf*.

[95] L. Perusse & C. Bouchard, *Gene-diet interactions in obesity*. Am. J. Clinical Nutrition; vol. 72 (5 Suppl.), pp. 1285S–90S (2000).

[96] Jon R. Gabel, et al., *Obesity and the Workplace: Current Programs and Attitudes Among Employers and Employees*, 28 Health Affairs 46–56 (2009).

[97] Antony D. Karelis, et al. *Metabolic and body composition factors in subgroups of obesity: What do we know?* J. 89 Clinical Endocrinology & Metabolism 2569–75 (June 2004); Neil Ruderman, et al., *The metabolically obese, normal weight individual revisited*, 47 Diabetes 699–713 (1998); Adam Gilden Tsai & Thomas A. Wadden, *Systematic review: An evaluation of major commercial weight loss programs in the United States*, 142 Annals of Internal Medicine 56–66 (Jan. 4, 2005).

[98] M.J. Franz, et al., *Weight-loss outcomes: A systematic review and meta-analysis of weight-loss clinical trials with a minimum 1-year followup.* 107 J. Am. Dietetic Ass'n 1755–67 (2007); L.P. Svetkey, et al., *Comparison of strategies for sustaining weight loss*, 299 JAMA 1139–48 (March 12, 2008).

[99] Rena R. Wing & Suzanne Phelan, *Long-term weight loss maintenance*, 82 Am. J. Clinical Nutrition 222S–5S (2005); Thomas A. Wadden, et al., *Efficacy of lifestyle modification for long-term weight control*. 12 Obesity Research 151S–162S. 11 (December 2004).

pressure and cholesterol levels.[100] Employees who fail these tests pay $780 more for annual individual coverage and $1,560 more for annual family coverage than employees who pass the tests.[101]

Many punitive wellness programs penalize employees whether or not they choose to participate in the programs. Scotts Miracle-Gro has implemented a program that imposes penalties for failure to participate in some aspects of the program.[102] Scotts' wellness program offers a health-risk appraisal called "Health Quotient."[103] Employees who choose not to participate pay a $40 per month insurance premium surcharge.[104] If an employee takes the appraisal and is in the mid- to high-tier range of risk levels, she can opt to consult a health coach and take steps to lower risks.[105] However, if the employee does not take further action, she will pay a $67 insurance premium surcharge—or penalty—per month.[106] Scotts' policy is a double-edged sword—if employees choose not to be evaluated, they incur a penalty, but agreeing to undergo the evaluation can come with even greater costs.

Several States penalize employees if their BMI—one of the most popular biometrics used by employers to measure health[107] and obesity[108]—exceeds a certain threshold. The State of Alabama has imposed financial penalties on its employees who have a BMI over 30,[109] and the State of North Carolina has denied its employees access to better health insurance options if an individual's BMI is above a certain measure.[110]

Notwithstanding the lack of evidence to demonstrate their efficacy, many employers have already implemented, or plan to implement, wellness programs that penalize employees who do not meet health criteria set by the employer, and that is cause for concern to those with an eye on nondiscrimination protections and makes even more important the EEOC's role in ensuring nondiscrimination.

Employers are increasingly relying on punitive wellness programs to control the cost of health benefits.[111] A 2010 survey by Hewitt of nearly 600 large U.S. employers (representing more than 10 million employees) found that nearly one-half (47 percent) already used or planned to use financial penalties over the next 3 to 5 years for employees. Of those companies using or planning to use penalties, the majority (81 percent) say they would do so through higher benefit premiums. Increasing deductibles and out-of-pocket expenses were also cited as possible penalties.[112] Interest in punitive wellness programs is on the rise. In Hewitt's most recent survey, published in March 2013, 58 percent of employers surveyed planned to impose consequences on participants who do not take appropriate actions for improving their health.[113]

Because women, racial minorities and older workers tend to be less likely to meet rigid health benchmarks, they are more likely to have to pay increased costs when financial penalties or rewards are associated with those benchmarks. As such, punitive wellness programs can run afoul of equal employment opportunity laws and the EEOC's role in identifying these programs is critical.

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[100] Steven A. Burd, *How Safeway Is Cutting Health-Care Costs*, Wall St. J., June 12, 2009, *http:// wsj.com/article/SB124476804026308603.html*.

[101] *Id.*

[102] Larry Hand, *Employer health incentives: Employee wellness programs prod workers to adopt healthy lifestyles,* Harvard Sch. Pub. Health Mag., (Winter 2009), *available at http://www.hsph.harvard.edu/news/magazine/winter09healthincentives*.

[103] *Id.*

[104] *Id.*

[105] *Id.*

[106] *Id.*

[107] Mike Stobbe, *Dieting for dollars? More U.S. employees trying it,* Fort Worth Star Telegram, June 2, 2010, *http://www.star-telegram.com/living/family/moms/article3825613.html*. As many as one-third of employers plan to implement financial incentive programs to encourage employees to reduce their BMI or other biometric markers of health. *Id.*

[108] Obesity Action Coalition, Measuring Weight and Obesity, *http://www.obesityaction.org/understanding-obesity/measuring-weight* (last visited Jan. 28, 2015).

[109] Shari Roan, *Alabama to place "fat tax" on obese State employees,* L.A. Times Blog, Aug. 25, 2008, *http://latimesblogs.latimes.com/booster_shots/2008/08/alabama-places.html*.

[110] 2009 N.C. Sess. Laws 16, *available at http://www.ncga.State.nc.us/Sessions/2009/Bills/Senate/PDF/S287v8.pdf*.

[111] *See* Michelle M. Mello, et al., *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359 N. Engl. J. Med. 192–99 (2008).

[112] Bloomberg.com, *Hewitt Survey Shows Growing Interest Among U.S. Employers to Penalize Workers for Unhealthy Behaviors* (March 17, 2010), *http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aqKgAGxn8bBA*.

[113] Aon Hewitt Survey Highlights Important Role of Incentives in U.S. Employers' Efforts to Improve Workforce Health and Performance, (2013), *http://aon.mediaroom.com/2013–03–25-Aon-Hewitt-Survey-Highlights-Important-Role-of-Incentives-in-U-S-Employers-Efforts-to-Improve-Workforce-Health-and-Performance*.

IV. CONCLUSION

When punitive wellness programs impose costs or withhold rewards from protected groups they violate well-established nondiscrimination laws. We urge this committee to support the EEOC's enforcement efforts to enforce nondiscrimination protections to ensure that employer wellness programs do not operate as a subterfuge for unlawful discrimination. Proper investigation and oversight by the EEOC is critical to ensuring that employer wellness programs help employees achieve meaningful improvements in health outcomes without running afoul of equal employment opportunity laws. Women, racial minorities and older workers are more likely to experience significant health disparities and are particularly vulnerable to chronic illnesses and therefore most likely to be impacted by wellness programs that discriminate. Employers should not use punitive wellness programs to shift costs disproportionately to these groups, particularly in light of the lack of evidence that punitive wellness programs actually improve employee wellness or decrease overall health care costs. Without congressional support, the EEOC's ability to promote equal opportunity and enforce civil rights laws for U.S. workers will be compromised.

Thank you for the opportunity to share our comments. We look forward to continuing to work with Congress and the Administration to ensure nondiscrimination in employer wellness programs.

PREPARED STATEMENT OF FAMILIES USA

Mr. Chairman Alexander, Senator Murray, and members of the committee: The undersigned organizations would like to submit the attached letter for the record for the hearing entitled, "*Employer Wellness Programs: Better Health Outcomes and Lower Costs*." This letter was sent by the undersigned organizations, representing diverse consumers and patients, to the Equal Employment Opportunity Commission (EEOC) on January 27, 2015. It commends the EEOC for its recent legal actions against select employers' wellness programs for violating the Americans with Disabilities Act (ADA) and other critical nondiscrimination laws (*EEOC* v. *Flambeau Inc.*, Civil Action No. 3:13-cv–00638; *EEOC* v. *Orion Energy Systems*, Civil Action 1:14-cv–01019; *EEOC* v. *Honeywell Inc.*, Civil Action 1:14-cv–04517). These actions are critical to ensuring that employers' wellness incentive programs preserve employees' rights under the ADA, the Genetic Information Nondiscrimination Act of 2008, and all other nondiscrimination laws, in addition to complying with requirements under the Affordable Care Act and HIPAA.

Thank you for the opportunity to submit this letter into the hearing record.

Sincerely,

AMERICAN DIABETES ASSOCIATION,
AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES,
AMERICAN SOCIETY OF BARIATRIC PHYSICIANS,
BINGEBEHAVIOR.COM,
EPILEPSY FOUNDATION,
FAMILIES USA,
OBESITY ACTION COALITION.

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION,
WASHINGTON, DC 20507,
January 27, 2015.

Cc: Secretary Sylvia Burwell, Department of Health and Human Services; Secretary Thomas E. Perez, Department of Labor

Re: EEOC Lawsuits Challenging Wellness Programs

DEAR COMMISSIONERS BARKER, BURROWS, FELDBLUM, LIPNIC, AND YANG: We, the undersigned organizations, are writing on behalf of the millions of patients, consumers, and workers that our organizations represent. We commend the Equal Employment Opportunity Commission (EEOC) for its recent legal actions against select employers' wellness programs for violating the Americans with Disabilities Act and other critical nondiscrimination laws (*EEOC* v. *Flambeau Inc.*, Civil Action No. 3:13-cv–00638; *EEOC* v. *Orion Energy Systems*, Civil Action 1:14-cv–01019; *EEOC* v. *Honeywell Inc.*, Civil Action 1:14-cv–04517).

The Americans with Disabilities Act (ADA), as amended by the ADA Amendments Act, places important limits on employers' abilities to make disability-related inquiries and to require medical examinations of their employees. Unless the examination or inquiry is "job-related and consistent with business necessity," any disability-re-

lated inquiries or medical examinations must be *voluntary for employees*, as part of an employee health program.

We agree with the EEOC, as asserted in their suits, that the aforementioned employers' wellness programs include penalties for not completing medical exams that are so large that they effectively make the medical exams involuntary and in violation of the ADA. These employers' penalties for non-participation include thousands of dollars in penalties tied to employees' medical plan costs, disciplinary action, and loss of any employer contributions to health care benefits. Such penalties could leave employees feeling that they have no choice but to provide private health information that, under the ADA, they have a legal right not to disclose.

In the case of Honeywell Inc., we have significant concerns with the company's penalty for nonparticipation in its wellness program's biometric testing, which is up to $4,000 in penalties tied to employees' medical plan costs and employer HSA contributions. This includes a tobacco surcharge of $1,000 on any individual who refuses to complete the medical exam, including employees and employees' spouses who do not use tobacco but do not wish to complete the exam for other reasons. For many working families who simply can't afford to pay this additional cost, programs with monetary penalties of this magnitude can be as coercive as programs that revoke all employer contributions toward an employee's health coverage if they do not participate.

Section 1201 of the Patient Protection and Affordable Care Act (ACA) allows employers to provide incentives for meeting certain wellness program requirements. However, this section only amended requirements of the HIPAA nondiscrimination and wellness provisions, under the Public Health Service Act and Employee Retirement Income Security Act. These provisions do not speak to the issue of how employers can gain access to an employee's health information. If Congress had intended for the ACA amendments to the HIPAA nondiscrimination and wellness provisions to override the ADA limitations on an employer's ability to request medical information about an employee or to require an employee to submit to a medical exam, it would have explicitly done so as part of the ACA wellness provisions. Just 2 years earlier, in the Genetic Information Nondiscrimination Act of 2008, Congress clearly addressed how job-based health plans could use genetic information (in title I amendments to ERISA) and how job-based health plans could inquire about genetic information (in title II amendments to the ADA). Absent language explicitly modifying the ADA provisions that limit employers' ability to request medical information or to require employees to submit to a medical exam, it seems clear that Congress intended to leave them intact.

Both Section 1201 of the ACA and enforcing regulations in §146.121 of the Code of Federal Regulations clearly state that compliance with wellness incentive requirements under HIPAA, as amended by the ACA, does not assure compliance with other Federal and State laws.[1]

The law is clear that employers must design and implement wellness incentive programs in a manner that ensures that they do not violate employees' rights under the ADA, the Genetic Information Nondiscrimination Act of 2008, and all other nondiscrimination laws, in addition to ensuring that they comply with requirements under the ACA and HIPAA. Therefore, it is the EEOC's duty to pursue these cases to ensure compliance with the ADA prohibition on compelling employees to disclose health information to their employers.

We thank the EEOC for taking action to ensure that employers' wellness programs are carried out in a nondiscriminatory manner that preserves all employees' rights.

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[1] §146.121(h) of the Code, states,

> *"compliance with this section is not determinative of compliance with any other provisions of the PHS Act (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act."*

The preamble to the 2013 final tri-agency rule enforcing ACA amendments to the HIPAA and wellness provisions of the PHS Act, "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans," also states that,

> *"the Departments recognize that many other laws may regulate plans and issuers in their provision of benefits to participants and beneficiaries. These laws include, but are not limited to, the ADA, Title VII of the Civil Rights Act of 1964, Code section 105(h) and PHS Act section 2716 (prohibiting discrimination in favor of highly compensated individuals), the Genetic Information Nondiscrimination Act of 2008, the Family and Medical Leave Act, ERISA's fiduciary provisions, and State law. The Departments did not attempt to summarize the requirements of those laws in the 2006 regulations and do not attempt to do so in these final regulations."*

If you have any questions or need additional information, please do not hesitate to contact Lydia Mitts, Senior Policy Analyst, Families USA, at 202-628-3030 or lmitts@familiesusa.org.

AMERICAN DIABETES ASSOCIATION,
AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES,
AMERICAN SOCIETY OF BARIATRIC PHYSICIANS,
BINGEBEHAVIOR.COM,
EPILEPSY FOUNDATION,
FAMILIES USA,
OBESITY ACTION COALITION.

CONSORTIUM FOR CITIZENS WITH DISABILITIES (CCD),
January 28, 2015.

Hon. LAMAR ALEXANDER, *Chairman,*
Committee on Health, Education, Labor, and Pensions,
455 Dirksen Senate Office Bldg.,
Washington, DC 20510.

Hon. PATTY MURRAY, *Ranking Member,*
Committee on Health, Education, Labor, and Pensions,
154 Russell Senate Office Building,
Washington, DC 20510.

DEAR SENATORS ALEXANDER AND MURRAY: We submit this letter on behalf of the Consortium for Citizens with Disabilities (CCD) Rights Task Force for purposes of the HELP Committee hearing tomorrow concerning employer-based wellness programs. CCD is a coalition of national disability organizations working for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

We applaud the committee for focusing on wellness programs, which we believe can play an important role in improving health outcomes for employees with disabilities and others. It is important to acknowledge, however, that wellness programs can and should be conducted consistently with civil rights laws. While the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act (HIPAA) set forth rules for the operation of wellness programs, other laws, such as the Americans with Disabilities Act (ADA), also apply to these programs. Indeed, the ACA did not supersede or eliminate the requirements of the ADA. Employer-based wellness programs should operate in ways that both promote better health outcomes and comply with the ADA's workplace protections. These protections do not conflict with the rules set forth in the ACA.

As you know, employment rates for people with disabilities have remained far below those for any other group tracked by the Bureau of Labor Statistics, and there is a particularly strong need for the EEOC to enforce the ADA's requirements and ensure that people with disabilities have full and fair opportunities to work. The disability community has always considered the EEOC's mission and work critically important. Overwhelmingly, people with disabilities want to work, and the EEOC's regulatory and enforcement activities have been tremendously significant in opening workplace doors and expanding opportunities for people with disabilities to become self-sufficient.

We support the EEOC's activities to enforce the rights of people with disabilities with respect to wellness programs. The EEOC's litigation in this area has focused on an issue of grave concern to us: punishing employees' failure to answer wellness program medical inquiries through penalties so steep that an employee's "choice" to answer the questions can hardly be considered voluntary. We believe that the Commission's enforcement activities in this area aim to safeguard a critical ADA protec-

tion, and they are also consistent with the ACA. Wellness programs can and should work well for all employees, including people with disabilities.

Sincerely,

JENNIFER MATHIS,
Bazelon Center for Mental Health Law.

MARK RICHERT,
American Foundation for the Blind.

CURT DECKER,
National Disability Rights Network.

SANDY FINUCANE,
Epilepsy Foundation of America.

CO-CHAIRS,
CCD Rights Task Force.

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION,
OFFICE OF COMMUNICATIONS AND LEGISLATIVE AFFAIRS,
WASHINGTON, DC. 20507,
February 6, 2015.

Hon. LAMAR ALEXANDER, *Chairman,*
Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC 20510.

DEAR CHAIRMAN ALEXANDER: Please accept this statement for the record from the Equal Employment Opportunity Commission (EEOC) in response to the Senate Committee on Health, Education, Labor, and Pensions' January 29, 2015 hearing entitled, "Employer Wellness Programs: Better Health Outcomes and Lower Costs." We write to provide additional information about the EEOC's enforcement and policies with respect to employer wellness programs in response to concerns raised at the hearing.

As you know, the EEOC is responsible for enforcing Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Equal Pay Act of 1963, the Americans with Disabilities Act of 1990, Section 501 of the Rehabilitation Act of 1973, the Civil Rights Act of 1991, the Genetic Information Nondiscrimination Act of 2008, the ADA Amendments Act of 2008, and the Lilly Ledbetter Fair Pay Act of 2009. Vested with this responsibility, the Commission is dedicated to achieving our national vision of justice and equality in the workplace by preventing, stopping and remedying unlawful employment discrimination.

The EEOC agrees that wellness programs can play an important role in controlling health care costs and promoting healthful lifestyles. We appreciate your statement that wellness programs cannot discriminate and that they must provide a reasonable alternative if an employee cannot meet the program's standard requirement.

NOTICE OF PROPOSED RULEMAKING (NPRM)

Several statements by Members and witnesses urged the EEOC to issue a rule to clarify the application of the ADA to workplace wellness programs. The Commission's fall 2014 regulatory agenda includes plans to publish a Notice of Proposed Rulemaking (NPRM) that will address the interaction between Title I of the ADA, which permits an employer to request medical information as part of a voluntary wellness program and HIPAA rules concerning wellness program incentives, as amended by the ACA. *See http://resources.regulations.gov/public/custom/isp/navigation/main.isp*.

Interested stakeholders will be invited to submit written comments on any issues related to the proposed rule. We will then carefully consider all comments we receive while developing the final rules.

The EEOC has been engaged in coordination with the Departments of Labor, Health & Human Services, and Treasury on these issues and continues to coordinate with these agencies as we move to publish the NPRM, consider the comments submitted during the public comment period, and prepare the final rules. The Commission appreciates the need for rulemaking in this area and intends to issue the NPRM as soon as possible.

EEOC ENFORCEMENT

The EEOC has filed two lawsuits on the merits concerning wellness programs, both of which were approved by a bi-partisan vote of the Commissioners. The first case filed was *EEOC* v. *Orion Energy Systems*, Civil Action I:14-cv-01019. **In that case, the EEOC alleges that Orion violated the ADA by requiring an employee to involuntarily submit to medical exams and inquiries that were not job-related and consistent with business necessity.** The EEOC alleges that the employer fired an employee in retaliation for declining participation in the program.

As set out in the EEOC's complaint, the wellness program at issue in *Orion* required employees to disclose their medical history and have blood work performed. The employee declined to participate in the wellness program. The EEOC alleges that if the employee had agreed to participate in the program, Orion would have covered the entire cost of her health insurance.

Because she declined to participate, the employee was required to pay the entire premium. In addition, the EEOC contends that Orion assessed an additional monthly penalty because she declined to participate in a fitness component of the program. Within approximately 6 weeks after the employee declined to participate pate, Orion fired her. The EEOC alleges that Orion fired her because she raised objections to the wellness program and declined to participate.

The second case filed was *EEOC* v. *Flambeau*, Civil Action No. 3:13-cv–00638. **As with the Orion case, the EEOC alleges that Flambeau violated the ADA.** The EEOC alleges that Flambeau's wellness program required that employees submit to biometric testing involving blood work and measurements and to disclose medical history. The EEOC alleges that Flambeau told employees that participation in the wellness program was mandatory in order to remain on the company's health insurance plan and that failure to appear for medical testing would result in unspecified disciplinary action. When one employee did not attend the scheduled medical testing, EEOC alleges that Flambeau notified him that it was canceling his health insurance and that he could apply for health insurance at the COBRA premium rate. The EEOC alleges that employees who participated in the wellness program, by comparison, were offered health insurance and were required to pay only 25 percent of their premium cost.

Regarding the Commission's recent application for preliminary relief with respect to its investigation into charges concerning Honeywell International, Inc., it is important to note that this action was not a lawsuit on the merits. The ADA and GINA empower the Commission to file actions for temporary relief, whenever the Commission concludes on the basis of a preliminary investigation that prompt judicial action is necessary to carry out the statutes' purposes. In this case, the Commission sought an injunction only to delay Honeywell from imposing penalties on employees (or their spouses) who chose not to participate in Honeywell's wellness program while the EEOC's investigation of the relevant charges continued. The Commission did not seek monetary damages or fines from Honeywell. In other words, under the limited relief the Commission sought, Honeywell would have been free to continue testing employees (and spouses) who voluntarily submit to biometric screening; Honeywell simply would have been prohibited from penalizing non-participating employees until the Commission had completed its investigation and processing of the charges. The district court denied the Commission's request for temporary relief. Consequently, the Commission's action for preliminary relief has concluded. There is no pending court action in this matter.

We appreciate the opportunity to provide additional information for the record and hope this information is help to you.

Sincerely,

TODD A. COX,
Director, Office of Communications and Legislative Affairs.

[Whereupon, at 11:31 a.m., the hearing was adjourned.]

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