National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

June 19, 2015

Submitted electronically via: www.regulations.gov

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

Re: RIN 3046-AB01 – Amendments to Regulations under the Americans with Disabilities Act

Dear Acting Executive Officer. Wilson:

The National Business Group on Health appreciates the opportunity to comment on the Commission's proposed amendments to ADA regulations related to employer-sponsored wellness program incentives. **We commend the Commission's efforts to provide clear and consistent guidance to employers on how the Americans with Disabilities Act (ADA) applies to employer-sponsored wellness program incentives** and to interpret the ADA in a manner consistent with the HIPAA and ACA provisions promoting these programs and the use of incentives. **However, as we recommend below, the EEOC can go further in aligning its rules, and, frankly, eliminating contradictions with these other laws that still remain in the proposed rule as it finalizes this rule in the months ahead**.

We specifically recommend the following, which are discussed in more detail below:

- **For the purposes of ADA compliance, incentives for outcomes-based wellness programs should be permitted up to 30% of the cost of the coverage that the employee is enrolled in. For those enrolled in family coverage, the relevant cost is the cost of family coverage, not employee-only coverage.**

- **Incentives for participation-only wellness programs should not be limited and they should not count toward the incentive cap for the purposes of ADA compliance.**

- **Incentives for tobacco cessation should be permitted up to 50% of the cost of coverage that the employee is enrolled in; irrespective of how tobacco-free status is determined.**

- **For the purpose of ADA compliance, conditioning eligibility for enhanced coverage on an employee's participation in a wellness program should be permitted as long as the employee who declines to participate is still eligible for employer-coverage that is affordable and comprehensive under the ACA.**

The National Business Group on Health represents 420 primarily large employers, including 70 of the Fortune 100, who voluntarily provide group health plan coverage and other health programs, including wellness programs, to over 55 million American employees, retirees, and their families. Our members employ and provide health coverage for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. They also often operate multiple lines of business in multiple states and tailor employee work and benefit arrangements to the specific needs of each line of business.

Employers have been at the forefront in designing innovative programs to encourage employees and their families to proactively engage in healthy lifestyles and preventive programs. Wellness and prevention programs are critical ways to improve the health of employees and their families, reduce preventable health care costs, maintain productivity in the workforce, and help employees lead more productive lives at home and in their communities. Moreover, employees like and value these programs and the programs also improve job satisfaction and retention.

Our employer members offer multifaceted, comprehensive wellness programs that address the wellbeing and health needs of employees and their dependents. Program components include health assessments, biometric screenings, questionnaires or other means of identifying clinical and lifestyle risks. Programs also have strong communications, education, counseling, coaching and other supports, activities, and services to help participants improve their health and reduce their risks. Common programs include weight management, physical activity and fitness, tobacco cessation, stress management, and specific programs targeted to cardiovascular disease, diabetes, depression, and other health conditions.

To encourage participation and achieve goals, wellness programs often include financial incentives. Wellness incentives take many forms, including premium discounts and surcharges, copayment and deductible waivers, health savings account and health reimbursement arrangement contributions, raffles, gift cards, and cash. These financial incentives generally form a part of comprehensive wellness strategies, as described above.

Many employers' incentives fall well below the 30% of cost of coverage threshold for outcome-based wellness incentives. According to the 2015 National Business Group on

Health/Fidelity Investments Sixth Annual Employer-Sponsored Health and Wellbeing Program Survey, the average employee-only incentive ranged from a high of $323 for tobacco cessation to a low of $127 for a physical activity program.

As our members continue to implement ACA, HIPAA, ADA, and other federal requirements applicable to wellness programs, primary concerns will be:

(1) Having flexibility to continue innovative plan designs with meaningful incentives that improve employee health and engagement and lower the overall cost of health coverage and

(2) Minimizing the administrative and cost burdens associated with complying with regulatory requirements.

Preserving plan design flexibility, providing meaningful incentives, and providing consistency with other federal statutes in the Commission's guidance and final regulations will reduce compliance burdens and allow plan sponsors to continue devoting resources to maintaining high-quality, cost-effective health coverage for employees and their dependents. To that end, we encourage the Commission, in developing guidance and final regulations for wellness programs, to take into account the features typical of large, self-insured employer-sponsored plans and their wellness programs. Specifically, we urge the Commission to consider the following:

- **Need for consistency in treatment of wellness programs and financial incentives for wellness under federal laws.** Our members provide group health plan coverage to large, diverse employee populations. Often, coverage options will vary widely within these populations. Changing wellness program designs to comply with new regulatory requirements involves extensive staffing resources and coordination between our members' payroll, human resources, and recordkeeping departments, as well as third-party wellness program partners—a process that involves substantial administrative and cost burdens. Therefore, in developing guidance and regulations for wellness programs, **we encourage the Commission to maintain consistency between ADA requirements and other federal requirements under HIPAA, the ACA, and ERISA**.

- **Need for flexibility in design.** Business Group members, because of their large employee populations, are in a unique position to achieve improved employee health, improved quality of care, and health care savings through innovative plan features such as wellness programs. **However, the risk of violating conflicting regulations will have a chilling effect on these innovations**. Therefore, the Commission's guidance and final regulations should not be overly prescriptive and limit newer program designs, such as those involving employees' family members and employees who choose not to participate in employer-sponsored group health plans.

We believe that the above approach will allow group health plans to continue to offer valued wellness programs that promote participants' health and productivity while accommodating individuals with disabilities; promote efficient, uniform plan administration; reduce plan administrative and cost burdens; and reduce the overall costs of health care for employers and employees.

We provide further discussion of these recommendations and responses to the Commission's specific requests for comment below.

I. Meaningful Incentives and Consistent Treatment of Wellness Programs under Federal Laws

A. The Business Group supports the Commissions' proposal to set the incentive limit for outcome-based wellness programs at 30% of the cost of coverage that the employee is enrolled in as permitted in the ACA, with the exceptions and changes addressed below that are consistent with the ACA and HIPAA.

Employers believe that the current HIPAA rules for wellness programs and incentives, and the ACA's expansion of allowable incentives, work well both for employers and for employees and are compatible with the ADA's purpose of preventing discrimination on the basis of disability.

To date, our members have complied in good faith with the wellness program requirements under HIPAA and the ACA and made reasonable accommodations for individuals with disabilities, as required by the ADA. Wellness programs are increasingly allowing employees to choose from a variety of health goals to obtain wellness incentives. We also note that our members do not offer and are not aware of wellness programs that do not provide support for participants to improve health. Rather, our members view wellness programs as valuable tools for improving participant health and productivity and reducing overall health care costs for employers and employees.

Therefore, ***we recommend that the Commission, in developing ADA guidance and regulations, maintain consistency with rules under HIPAA and the ACA to the maximum extent possible***. Specifically:

- Guidance or final regulations should permit plan sponsors to continue offering incentives of up to 30% of the total cost of coverage for employee-plus-dependent coverage if dependents (such as spouses or children) are eligible to participate in an outcome-based wellness program. This design is increasingly popular among plan sponsors and, based on our members' experience, has contributed to increased engagement by spouses and dependents as well as employees. Engaging the entire household in wellness reinforces healthy lifestyles at home and helps all members of the family improve their health and make better health choices. Furthermore, HIPAA and the ACA tie maximum incentives for outcome-based

wellness programs to the total cost of the type of coverage that the employee enrolls in, not just employee-only coverage. Therefore, we were surprised and disappointed to see the EEOC limit incentives to employee-only coverage in the proposed rule. ***To be consistent with HIPAA and the ACA, the Commission should correct this oversight and limit incentives for outcome-based wellness programs to 30% of the cost of coverage that the employee is enrolled in. For those enrolled in family coverage, the allowable incentive should be up to 30% of the cost of family coverage, not employee-only coverage.***

- Guidance or final regulations should continue to permit plan sponsors to continue offering unlimited incentives for participation-only wellness programs and incentives for these types of programs should not count toward the maximum for outcome-based programs. While an individual has a choice to decline participation in this type of wellness program, for example a nutrition and diet class or an educational program about the benefits of relaxation and stress management, we do not see the need nor do we support including incentives for these types of programs toward the incentive cap. Furthermore, neither HIPAA nor the ACA limit incentives for participation-only wellness programs. ***To be consistent with HIPAA and the ACA, the Commission should not limit incentives for participation-only wellness programs and should not count any incentives for these types of programs to the incentive cap.***

- Guidance or final regulations should continue to permit plan sponsors to offer incentives up to 50% of the total cost of coverage that the employee is enrolled in for tobacco cessation programs, regardless of whether determination of tobacco status is self-reported or is verified by an exam. The enormous health and economic benefit to the individual, their families, and society of helping people to quit tobacco is without question. That is why the ACA permitted incentives for tobacco cessation to be as large as 50% of the total cost of coverage. Again, we were surprised and dismayed to see the Commission propose to limit the incentive to 30% if a test such as for cotinine is used to verify tobacco-free status. Not only is this limit inconsistent with the ACA, tobacco use or smoking are not considered protected under the ADA. ***To be consistent with the ACA, and because of the dangers of tobacco, the Commission should permit incentives for tobacco cessation programs up to 50% of the total cost of coverage the employee is enrolled in even if a test is used to determine tobacco-free status as long as the test is limited to that and not used for any other purpose.***

- Guidance or final regulations should continue to permit plan sponsors to require participation in a wellness program in order to be eligible to enroll in a benefit plan as long as the plan sponsor offers non-participants comprehensive, affordable (ACA compliant) coverage under a different group health plan or benefit package. If the Commission adopts the proposed prohibition on so-called “gateway” plans, it will prohibit many highly successful programs that require employees to complete health assessments or biometric screenings in order to qualify for some

(but not all) health benefits packages. If it is included in the final rule, the proposed regulation would unnecessarily eliminate an effective way to increase health engagement, which is the sole purpose of the medical inquiry, not to gain disability-related information. Properly designed gateway programs are voluntary and non-coercive. Often, the only difference in plans is a difference in deductibles, copayments, and coinsurance that increases the actuarial value of the gateway plan by a small percentage and may even have a slightly higher premium. Nevertheless, the other coverage available still satisfies the comprehensive coverage and the affordability requirements of the ACA and in fact can have a lower premium because of the higher cost sharing.

The proposed regulation's focus exclusively on cost-based incentives disadvantages employers and employees alike. The proposed regulation permits an employer to offer the same group health plan to all employees, but to charge a significantly higher premium for employees who decline to participate in a wellness program. Employees perceive the higher premiums as a penalty. In contrast, with gateway plans, the "reward" for participating in a wellness program is participation in an actuarially more valuable, but sometimes more costly plan. Under this design, an employee who prefers to enroll in a less expensive health option is not at all at a disadvantage if he or she also declines to participate in the wellness program.

It is clear and we agree that a wellness program is inappropriately coercive if the program denies access to meaningful health coverage to employees who decline to participate in wellness programs. We do not ask the Commission to authorize wellness programs with this design. Instead, **we believe that the regulation should allow an employer to condition eligibility for enhanced health coverage on the employee's participation in a wellness program as long as an employee who declines to participate is still eligible for employer-provided health coverage defined as affordable, minimum value coverage under the ACA.**

This proposal is consistent with the Commission's goal of limiting incentives for wellness programs to prevent coercion that could make the provision of medical information involuntary. Because employees who decline to participate in wellness activities still have access to employer-sponsored coverage that is comprehensive and affordable, a gateway program with this type of design is not inappropriately coercive. ***The Commission should make clear that ADA permits these programs as long as the employer offers affordable, comprehensive (ACA-compliant) health coverage to those who decline to participate in wellness activities.***

- Guidance or final regulations should permit plan sponsors to continue offering incentives for wellness program activities outside the group health plan context. These types of activities—including exercise programs, weight loss challenges,

and wellness-themed raffles and prizes—generally are not considered ERISA-covered group health plan benefits and are not subject to HIPAA. However, they often form part of an overall wellness strategy and have proven effective in increasing employee engagement and participation in other health programs.

We also caution the Commission not to create overly burdensome administrative requirements that will do little to benefit employees. Specifically:

- Because our members already accommodate individuals with disabilities in their wellness program designs, it is unnecessary to require programs to offer similar incentives to persons who choose not to disclose medical information and provide certification from a medical professional stating that the employee is under the care of a physician and that any medical risks identified by that physician are under active treatment. We believe that the current rules under HIPAA and the ACA offer ample opportunities for individuals with disabilities to obtain incentives. Creating an additional "doctor's note" requirement would involve substantial administrative and cost burdens with little benefit to employees or employers.

- For similar reasons, final regulations should not include a requirement that employees participating in wellness programs that include disability-related inquiries and/ or medical examinations, and that are part of a group health plan, provide prior, written, and knowing confirmation that their participation is voluntary.

- Likewise, requiring employers to track whether incentives render coverage unaffordable would present significant administrative and cost burdens. Employers generally do not maintain information about employees' household income, and requiring employers to do so would not only be impractical but would not address the ADA's goal of protecting employees with disabilities.

- Generally, we do not believe a new and separate notice requirement should be required, especially for wellness programs that are already subject to HIPAA, because relevant information is already provided through other means. However, if a notice is found to be necessary, we believe it should be limited to the types of wellness programs that provide more than "de minimis" rewards described in the proposed regulation's specific request for comment.

B. We encourage the Commission to consider a "Safe Harbor" for HIPAA Privacy and Security Rules.

Although many wellness programs do ask participants to provide health information, it is important to remember that existing privacy laws—particularly those under HIPAA—provide a strict and comprehensive set of protections for that information.

The HIPAA Privacy Rule generally requires that entities covered by the Privacy Rule—including group health plans (and their wellness programs) and health care providers—not use or disclose protected health information (PHI)[1] unless the person who is the subject of that information authorizes such use or disclosure or unless the Privacy Rule explicitly permits or requires such use or disclosure.[2] The Privacy Rule also gives individuals specific enumerated rights with regard to their health information and how it is used.[3]

The Privacy Rule allows group health plans to share PHI with plan sponsors for plan administration functions. However, before plans can do so, they must receive certification from plan sponsors that plan documents have been amended to impose restrictions on the plan sponsors' use and disclosure of the PHI. These restrictions must include a representation that plan sponsors will not use or disclose the PHI for any employment-related action or decision or in connection with any other benefit plan.[4] To comply with the HIPAA Privacy Rule, plan sponsors generally use third-party vendors to operate wellness programs. Under this arrangement, plan sponsors can receive health information about plan participants in the aggregate but will not receive individually identifiable health information.

In addition, under the Privacy Rule, a group health plan (including its wellness program) must:

- Provide a Notice of Privacy Practices that provides notice of how the plan may use and disclose PHI about individuals, as well as their rights and the plan's obligations with respect to that information.
- Designate a privacy official who is responsible for implementation and development of privacy policies and procedures;
- Train its employees on its privacy policies and procedures;
- Implement administrative, technical, and physical safeguards to protect the privacy of PHI;
- Provide a process for individuals to make complaints concerning the plan's privacy policies and procedures;
- Develop sanctions for employees or business partners who violate the plan's privacy policy or procedures;
- Mitigate, to the extent practicable, any harm that might occur from improper use or disclosure of PHI;

[1] PHI generally includes any individually identifiable health information. *See* 45 C.F.R. § 160.103.

[2] 45 C.F.R. § 164.502.

[3] *See, e.g.*, 45 C.F.R. § 164.522 (right to request privacy protection for PHI); 45 C.F.R. § 164.524 (right to access PHI); 45 C.F.R. § 164.528 (right to accounting of disclosures of PHI).

[4] *See* 45 C.F.R. § 164.504(f).

- Not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals exercising their rights under the Privacy Rule or individuals participating in the filing of a complaint under the Privacy Rule;
- Not require individuals to waive their rights under the Privacy Rule as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits;
- Implement written policies and procedures with respect to PHI that are designed to comply with the Privacy Rule; and
- Maintain the policies and procedures above in written or electronic form, maintain copies of any communications required to be in writing by the Privacy Rule, maintain copies of any actions that the Privacy Rule requires to be documented, and retain any such copies or records for six years from the date of creation or the date last in effect, whichever is later.[5]

Our members devote considerable resources toward developing and implementing policies and procedures that protect all PHI—not just PHI provided through wellness programs. Given HIPAA's robust privacy protections and enforcement mechanisms, we encourage the Commission, in final regulations, to make available a "HIPAA safe harbor" whereby any wellness program that complies with relevant HIPAA rules would be deemed to comply with applicable EEOC standards, rather than outline separate (but similar) requirements under 29 C.F.R. § 1630.(d)(4)-(6). This safe harbor would eliminate confusion as to plan sponsors' obligations in protecting plan participants' health information.

II. Effective Wellness Programs Require Flexibility in Design.

Although the bulk of the Commission's guidance regarding wellness programs focuses on the ADA's prohibition on medical examinations and disability-related inquiries and its application to financial incentives linked to wellness activities,[6] we encourage the Commission, in developing final regulations, to consider that for our members, financial incentives are merely a part of an employer's overall wellness strategy. As large employers, our members are at the forefront of developing and implementing new health and wellness strategies and regularly reevaluate and modify their wellness programs to maximize participation and effectiveness. These programs are ever more important in a difficult economic environment, with growing workplace stress and unhealthy lifestyles increasing not only health plan costs but also more hidden costs such as employee absence.[7] Therefore, we urge the Commission not to develop an overly prescriptive approach that stifles innovation in employer-sponsored wellness programs.

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[5] *See* 45 C.F.R. §§ 164.500-534.

[6] *See, e.g.*, EEOC Informal Discussion Letter (Mar. 6, 2009); EEOC Informal Discussion Letter (Aug. 10, 2009); EEOC Informal Discussion Letter (Jun. 24, 2011).

[7] *See* Towers Watson and National Business Group on Health, *Pathway to Health and Productivity: 2011/2012 Stay@Work Survey Report, available at* http://www.businessgrouphealth.org/pub/f30cd456-2354-d714-51e4-d18a8e449fff (last visited May 22, 2013).

As noted above, National Business Group on Health members employ and provide health benefits for employees in many different industries and work arrangements. To accommodate the health care needs of their large and varied employee populations, our members provide a wide variety of health plan options at different cost and coverage levels. Along with health plan options, many of our members offer and are expanding wellness programs with the goal of engaging their employee populations in health and productivity efforts. These wellness programs often involve a number of different components such as:

- Disease management programs;
- On-site or near-site health clinics;
- Health risk assessments;
- Biometric screenings;
- Health coaching by health professionals;
- Information campaigns on healthy lifestyles and nutrition;
- On-site exercise facilities
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- and classes;
- Discounts or company subsidies for off-site exercise facilities and classes;
- Employee assistance programs that address physical and mental health, workplace stress, caregiving challenges, and other issues; and
- Employee fitness challenges (such as exercise or weight loss competitions).

In many cases, our members have devoted significant financial, administrative, and staff resources to ensure that their wellness programs are tailored to needs, culture, and specific health concerns of their plan populations. Many of our members also have implemented extensive communications efforts—such as web portals, print communications, and having employees serve as "wellness champions"—to educate participants about healthy behaviors and increase participation in wellness programs. Because our members maintain a strong focus on evidence-based, cost-effective health coverage, many will want to adapt and modify their wellness programs as new research and technologies become available, with the goal of improving participant health and productivity and increasing overall cost savings

For the reasons above, we encourage the Commission to allow plan sponsors the flexibility to design and modify wellness programs to reflect the needs of their workforces.

III. Effective Date

Finally, we recommend that in setting an effective date for final regulations, the EEOC consider the administrative requirements of large, self-insured group health plans. Most of our members implement plan design changes on a plan year basis, which may or may not coincide with the calendar year. In addition, because our members' plans (1) cover large populations, (2) often include different plan options and designs tailored to specific

participant populations, and (3) often require coordination with multiple third-party administrators and vendors; our members tend to finalize any plan design changes up to a year before their implementation. ***Therefore, we recommend that any amendments to ADA regulations related to wellness programs become effective no earlier than the first day of the first plan year beginning 12 months after the issuance of final regulations, which would be consistent with other laws and regulations affecting employer plans.***

Again, thank you for considering our comments and recommendations on the proposed amendments to ADA regulations related to wellness programs. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian Marcotte
President