



**Wellness Programs and Nondiscrimination
Under Employer-Sponsored Group Health Plans**

**Testimony of Karen Pollitz, Senior Fellow
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Before the Equal Employment Opportunity Commission

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Good morning Chair Berrien and Members of the Commission and thank you for inviting me to participate in this meeting today on employer sponsored wellness programs. My name is Karen Pollitz, and I am a senior fellow at the Henry J. Kaiser Family Foundation, working on our initiative to monitor the implementation of private health insurance-related provisions of the Affordable Care Act (ACA). Kaiser is a non-profit, private operating foundation focusing on the major health care issues facing the U.S., as well as the U.S. role in global health policy. We serve as a non-partisan, expert source of facts, information, and analysis for policymakers, the media, the health care community, and the public. The Kaiser Family Foundation is not associated with Kaiser Permanente or Kaiser Industries.

My remarks this morning focus on a proposed regulation, published last November, governing the design and application of wellness programs offered in connection with employer-sponsored group health plans.

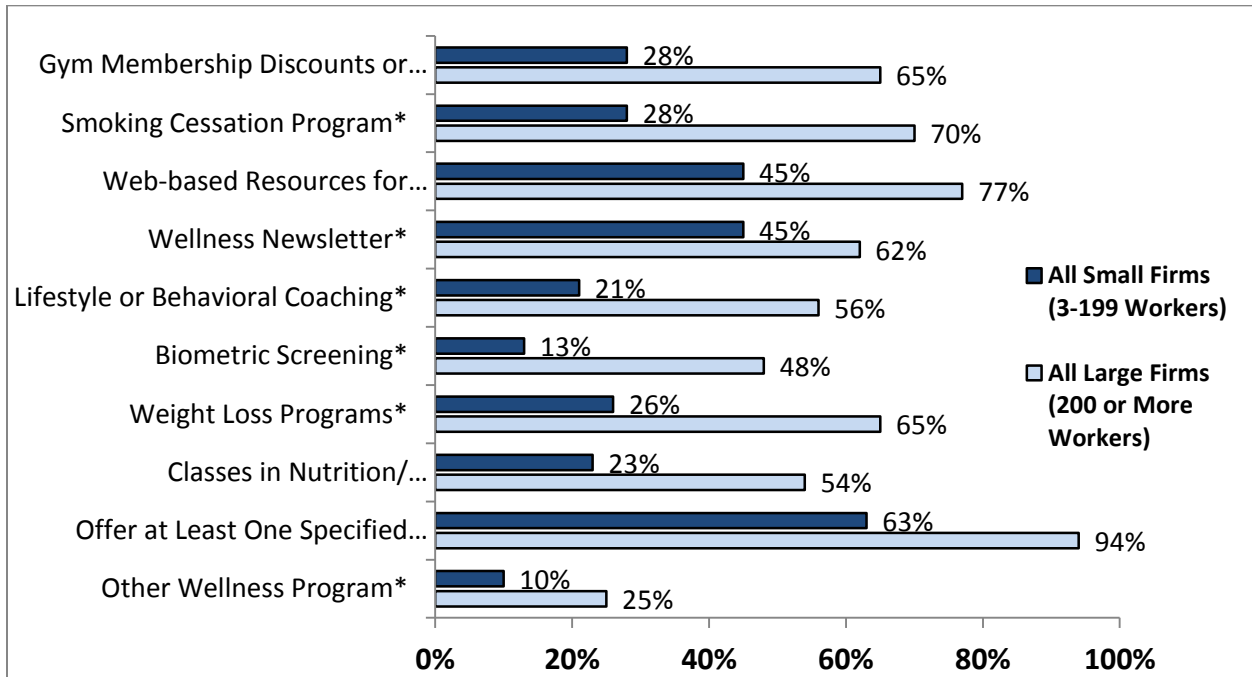
Background on wellness programs and employer-sponsored group health plans

Wellness programs are intended to provide support and incentives to employees to adopt healthier lifestyles or take other actions to improve health. The Kaiser Family Foundation's Annual Employer Health Benefits Survey tracks the development of employer-sponsored wellness programs.¹ Our 2012 survey found that most firms offering health benefits offer some type of wellness program, with 94 percent of large firms (200 or more workers) and 63 percent of smaller firms (3-199 workers) offering a wellness benefit. Sixty percent of firms offering health benefits and wellness benefits offer the wellness benefits to spouses or dependents. When asked why they offer programs, 37 percent of employers cite as their primary reason that the wellness program was part of their health plan, while an almost equal percentage (35%) say their primary reason is to improve the health of employees and reduce absenteeism. Fewer firms identify improving morale and productivity (9%) or reducing health costs (9%) as their primary reason. The types of wellness programs offered vary from offering a wellness newsletter to sponsoring weight loss and smoking cessation programs, nutrition classes, on-site exercise facilities, and other activities. (See Exhibit A)

Firms use various methods to identify individuals with health risks and encourage their participation in wellness programs. Twenty-four percent of firms offering health benefits and wellness programs report using health fairs to identify individuals and encourage participation in wellness programs. Eleven percent of firms offering health benefits and wellness programs use claims to identify individuals with health risks and encourage wellness participation. And forty-six percent of firms offering health benefits and wellness programs use a health risk assessment to identify individuals and encourage wellness program participation. Health risk assessments generally include questions about a person's medical history, health status, and lifestyle. Large firms are more likely than small firms to employ each of these methods to identify individuals. (See Exhibit B)

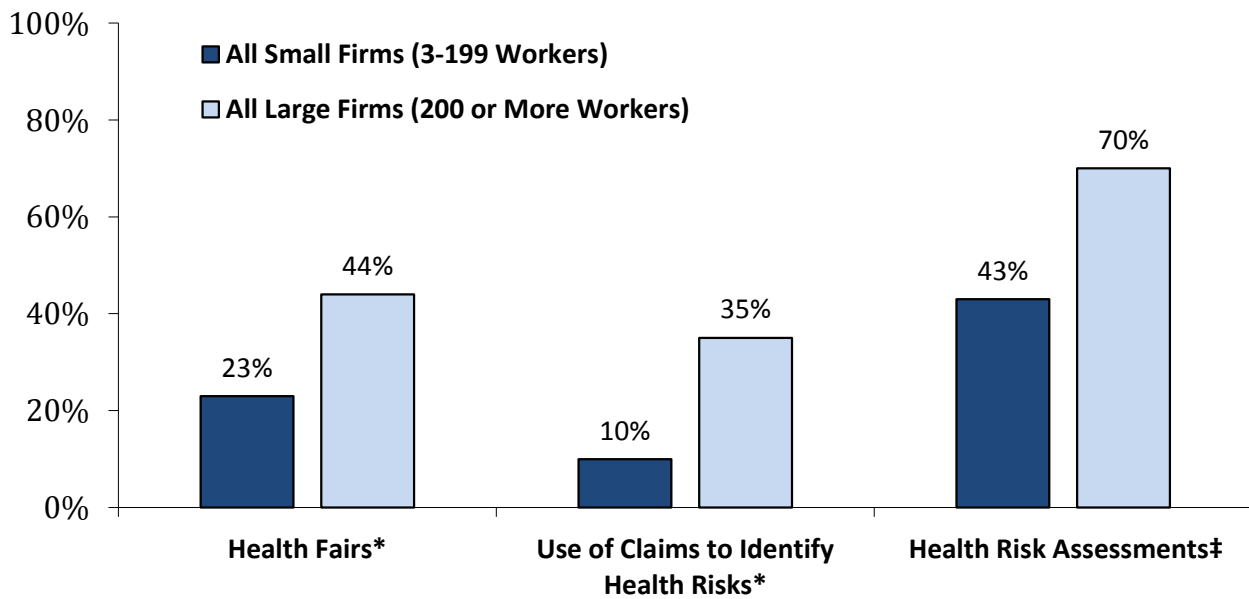
¹ Kaiser Family Foundation, Employer Health Benefits 2012 Annual Survey, available at <http://ehbs.kff.org>.

Exhibit A
Among Firms Offering Health Benefits, Percent Offering Certain Wellness Programs, 2012



* Estimate is statistically different between All Small Firms and All Large Firms within category (p<.05).
 SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

Exhibit B
Method Used to Identify Individuals for Participation in Wellness Programs, 2012

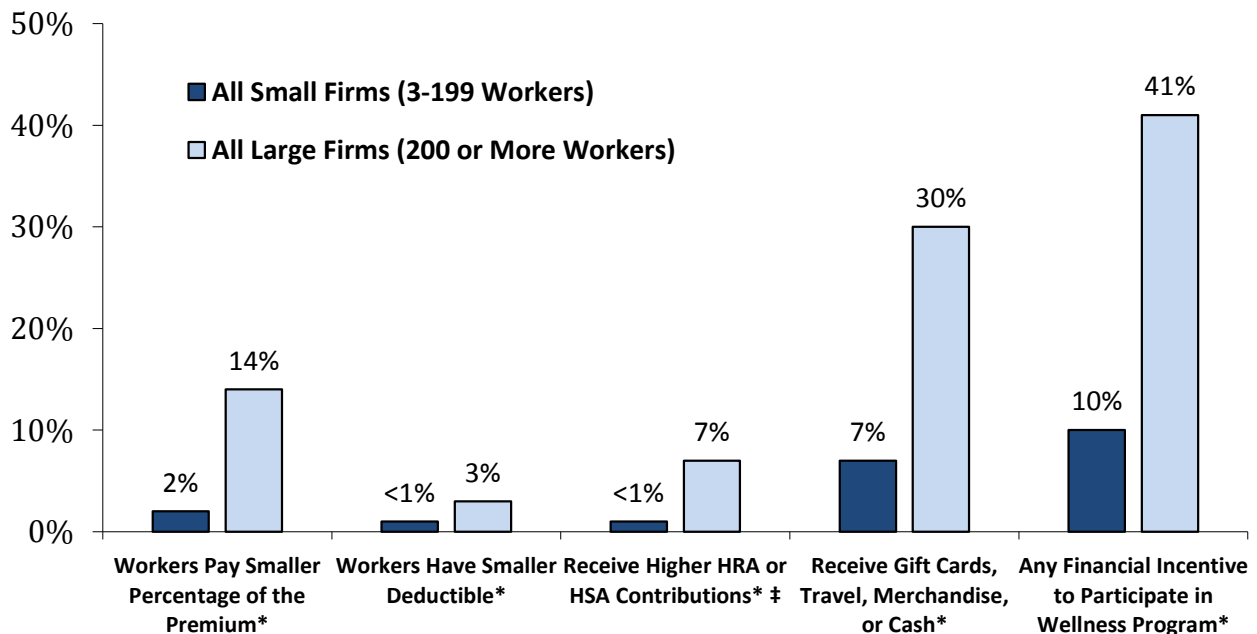


* Estimate is statistically different between All Small Firms and All Large Firms within category (p<.05).
 ‡ A firm's use of health risk assessments is asked only of firms who ask employees to complete a health risk assessment.
 Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

Among firms offering wellness programs, 10 percent of small firms and 41 percent of larger firms offer financial incentives for individuals to participate. Mostly, these take the form of gift cards, merchandise, or cash. Much less often, the incentive takes the form of a reduced premium contribution or reduced deductibles or other cost sharing within the group health plan. (See Exhibit C) Some firms offer financial incentives to encourage employees to complete health risk assessments. Of large firms offering health benefits and health risk assessments, 63 percent offer a financial incentive to complete the questionnaire. A smaller proportion of programs use financial incentives to encourage employees to participate in a wellness program and/or to meet biometric outcomes. Eleven percent of large firms that ask employees to complete a health risk assessment reported that employees with an identified health risk factor may be required to complete a wellness or health management program or activity in order to avoid a financial penalty, such as a higher premium contribution or cost sharing. Nine percent of large firms who ask their employees to complete a health risk assessment report that employees are rewarded or penalized financially based on whether they meet specified biometric outcomes (not including smoking cessation), such as meeting a target body mass index (BMI) or cholesterol level.

While it is relatively uncommon today for group health plans to vary premium contributions or cost sharing as a wellness incentive, the context in which such decisions are made may change. In 2014 new ACA rules will take effect requiring large employers to offer health coverage or pay a penalty, prohibiting issuers from discriminating based on health status, and setting new standards for wellness programs.

Exhibit C
Among Firms Offering Wellness Benefits, Percentage Offering Specific Incentives to Employee Participation in Wellness Programs, 2012



* Estimate is statistically different between All Small Firms and All Large Firms within category (p<.05).

‡ Only firms that offer an HDHP/HRA or HSA-qualified HDHP were asked if participating employees receive higher HRA/HSA contributions as an incentive to participate in wellness programs.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

Wellness incentives and nondiscrimination since 1996

Since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which established the federal requirement that employer-sponsored group health plans cannot discriminate against group members based on health status, an exception has been permitted for wellness programs that offer financial incentives, such as discounts on premium contributions for health benefits. This exception has evolved over time through regulatory and statutory interpretation.

HIPAA standards, 1996 - Interim final rules to implement HIPAA, issued in 1997, permitted group health plans to establish premium discounts or rebates or to modify cost sharing under the plan in return for adherence to wellness programs.² The 1997 rule made clear that under no circumstances could wellness programs condition receipt of the reward based on health-status-related factors. The 1997 rule noted, for example, that a program providing premium discounts only to enrollees who can achieve a blood cholesterol count under 200 would be considered to discriminate impermissibly based on a health status-related factor.

HIPAA amendments, 2006 - About a decade later, the nondiscrimination rule was re-interpreted and the wellness program exception for group health plans significantly modified.³ The 2006 amended rule recognized two types of wellness programs – those that condition a reward based on an individual’s ability to achieve a health-status-related factor, and those that do not. Health-factor based wellness programs would not be considered discriminatory if they met 5 standards:

- Reasonably designed – The rule defined a reasonably designed program as one that has a reasonable chance to promote health or prevent disease, is not overly burdensome, is not a subterfuge for discrimination based on health status, and is not highly suspect in the method chosen to promote health or prevent disease. The preamble to the 2006 rule stressed that the “reasonably designed” standard was designed to prevent abuse, but otherwise was “intended to be an easy standard to satisfy...There does not need to be a scientific record that the method promotes wellness to satisfy this standard. [It] is intended to allow experimentation in diverse ways of promoting wellness. For example a plan...could satisfy this standard by providing rewards to individual who participated in a course of aromatherapy.”
- Limit on the reward – The 2006 rule said that under a health-factor based wellness program, the reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanisms (such as deductibles or copays), the absence of a surcharge, or the value of a benefit that would not otherwise be provided under the plan. The size of the reward could not exceed 20 percent of the entire cost (employer and employee contribution combined) of self-only coverage or, if spouses and children can participate in the program, of family coverage.
- Reasonable alternative standard – The 2006 rule required plans to also offer a reasonable alternative standard for obtaining the reward for certain individuals. The alternative standard must be available for individuals for whom it is medically inadvisable or difficult to satisfy the

² <http://www.gpo.gov/fdsys/pkg/FR-1997-04-08/pdf/97-9124.pdf>

³ <http://www.gpo.gov/fdsys/pkg/FR-2006-12-13/pdf/06-9557.pdf>

otherwise applicable standard. The rule noted it is permissible for a plan to devise a reasonable alternative standard by lowering the threshold of the existing health-factor-related standard, substituting a different standard, or waiving the standard.

- Opportunity to qualify for the reward – Under the rule, individuals had to be given at least one opportunity each year to qualify for the reward.
- Notice – All plan materials that describe the terms of the program must also disclose the availability of a reasonable alternative standard.

In addition, the 2006 regulation specified that “Compliance with this section is not determinative of compliance with ... any other State or Federal law, such as the Americans with Disabilities Act...”

ACA Standards, 2010 - The Affordable Care Act codified the main features of the 2006 rules, changing one. It said wellness programs that establish incentives or rewards based on health-status-related factors are allowed, as long as they meet at least the five standards outlined in the 2006 regulation. The ACA increased the maximum allowable reward to 30 percent of the plan cost and gave the Secretary authority to increase it further to 50 percent. It also gave the Secretary authority to publish implementing regulations.

In November 2012, a notice of proposed rulemaking (NPRM) was published outlining amendments to the 2006 rule.⁴ The NPRM maintained the requirement of reasonable design, restating the 2006 language that this requirement is intended to be an easy standard to satisfy. In addition, it proposed to change the 2006 standards in the following ways:

- Limit on reward – The proposed rule would increase to 30 percent the maximum reward allowable under reasonably designed programs. In addition, to the extent that a wellness program targets tobacco use and assigns at least 20 percentage points of the reward toward that goal, the maximum reward allowable could be 50 percent of plan costs.
- Reasonable alternative standard – The proposed rule would make several changes in this standard. First, it would require that all individuals who cannot satisfy the initial standard must be offered a reasonable alternative means to qualify for the reward. Employers would have flexibility to design the reasonable alternative means; however, if the alternative involves a class or program that charges a membership fee, the employer would be required to pay that fee. In addition, an individual’s physician would have the final say on whether it is medically inadvisable for that person to satisfy the initial or alternative standard, and if so, a medically appropriate standard for that person would have to be offered or the standard would be waived.

The proposed rule offered illustrations of programs that would be considered reasonably designed. Under one example, the wellness program might offer a reward to any employee whose blood cholesterol level is under 200, but offer to anyone who fails that standard an alternative way to earn the reward by simply participating in a walking program three times a week, regardless of whether this

⁴ <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28361.pdf>

results in actually lowering cholesterol levels. Whether other program designs would be considered reasonable was not clearly spelled out nor illustrated.

Questions and issues pending final wellness rule

Allowing variation in health insurance premium contributions, cost sharing or benefits based on health status as a wellness incentive, by definition, involves tradeoffs. On the one hand, if such programs effectively promote wellness and prevent disease, they could help to improve population health and, at least over the long term, help to reduce health care spending associated with certain conditions or risk factors that wellness programs target. On the other hand, to the extent such programs make it more expensive for individuals with health problems to participate in group health plan benefits in the near term, they might also promote loss of coverage for individuals with poorer health status and undermine risk pooling.⁵

Depending on the content of the final regulation, how these tradeoffs are balanced may become somewhat clearer. For example:

Definition of “burdensome” or “subterfuge for discrimination” - Under the proposed rule, two of the requirements for a reasonably designed wellness program are that it must not be overly burdensome or a subterfuge for discriminating based on a health factor. However, the proposed rule – like the 2006 regulation it would amend – does not elaborate on these standards nor offer any examples of programs that would be considered overly burdensome or discriminatory. One recent report describes a program operating under current regulations that might or might not be considered reasonable under the proposed rule. That program required participants to meet five fitness tests in order to avoid paying a higher premium contribution for job-based health benefits. One participant who failed to meet one of the tests – a target BMI of 24 – while she was pregnant had this standard waived during her pregnancy, but the test was reinstated once the baby was born. Then the woman’s physician advised that it was medically inadvisable for her to try to lose weight while breast feeding. So the employer offered an alternative standard – to work with a trainer in the company gym for 130 minutes per week outside of normal business hours. The woman could not meet this standard in light of the time demands of caring for a newborn, and as a result, her required monthly premium contribution for family health coverage increased from \$175 to \$320 per month.⁶

The proposed rule does offer a specific example of a permissible health factor – blood glucose levels – that could be the subject of wellness incentives. The proposed rule does not offer any guidance, however, on whether a wellness program would be considered reasonably designed or a subterfuge for

⁵ As an example, one wellness program marketed to small employers notes that health plan savings can be realized, in part, because some employees will choose to leave the plan. See http://www.benicompadvantage.com/index.php?option=com_content&view=article&id=16:employer-faqs&catid=4:resources-a-tools&Itemid=20

⁶ Volk, J and Corlette, S, “Premium Incentives to Drive Wellness in the Workplace: A Review of the Issues and Recommendations for Policymakers,” Georgetown University Health Policy Institute, February 2012. Available at <http://www.rwjf.org/content/dam/web-assets/2012/02/premium-incentives-to-drive-wellness-in-the-workplace>

discriminating based on a health factor if it had the effect of systematically raising the cost of health benefits for participants who suffer from diabetes.

Wellness incentives and older workers - Older workers potentially could face more costly wellness incentives. Under other final ACA regulations, employers will be allowed to assign to each worker their underlying cost of coverage, adjusted by age and tobacco use. That rule also permits flexibility for tobacco adjustments to vary by age (e.g., a 10 percent tobacco surcharge might apply for younger individuals but a 50 percent surcharge for older individuals.)⁷ The wellness NPRM doesn't specify whether or not employers and insurers could also vary wellness rewards and incentives by age. If they do, older workers could face much higher penalties for failing to meet certain health measures.

Wellness incentives and employer responsibility requirements – To date, how wellness incentives might interact with the ACA's requirement that large employers offer affordable health benefits has yet to be specified. The ACA requires that when an employee's contribution for large employer health plan coverage exceeds 9.5% of her income she can seek subsidized coverage in the Exchange and, if she does, her employer can be liable to pay a tax penalty. How will premium surcharges resulting from wellness programs be considered in determining the affordability of employer-sponsored coverage? Taking them into account might deter employers from adopting wellness programs with premium-based incentives as large as the ACA allows. Not taking them into account, though, could allow employers to set premium contributions that are less affordable for sicker employees without triggering tax penalties.

Wellness incentives and other group health plan standards - Also yet to be spelled out is how wellness programs would interact with ACA standards for the affordability and minimum value of group health plans. The wellness NPRM allows deductibles and other cost sharing to vary by up to 50 percent of total plan cost, which could amount to thousands of dollars for an individual. However, the ACA also limits total cost sharing for an individual in a year to roughly \$6500 in 2014. Could wellness program penalties result in some group plan participants facing cost sharing above these limits? The ACA also sets actuarial value standards for group health plans. In essence, the actuarial value of a plan measures the level of cost sharing it imposes on covered benefits. Large employer plans are required to offer a minimum value (MV) of 60 percent. Would the AV or MV standard for a plan be evaluated taking into account wellness incentives, or without regard to them?

Wellness incentives and other federal nondiscrimination laws - Finally, questions of particular concern to this Commission relate to how employer-sponsored wellness programs authorized under ERISA may be treated under other federal laws prohibiting discrimination in employment. The Americans with Disabilities Act (ADA), for example, prohibits employers from collecting health information about employees except under limited circumstances, including when information is collected as part of a voluntary wellness program. How is "voluntary" defined? If the incentive to complete a health risk assessment is to avoid a premium surcharge of \$2,000 per year, can a low-wage worker be considered to voluntarily provide such personal health information? Or if, as the wellness NPRM notes, a reward takes the form of the absence of a surcharge and all participants receive the penalty by default unless

⁷ <http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf>

they affirmatively act to avoid it, is participation in such a program considered to be voluntary or based on automatic enrollment? How, if at all, might ADA-related standards apply to the reasonable alternatives employers must offer to individuals who fail to meet a wellness program's initial biometric measure?

In addition, other laws – such as the Age Discrimination in Employment Act, the Equal Pay Act, and Title VII of the Civil Rights Act – which prohibit discrimination in pay and benefits based on age, sex, race, color, and national origin may also apply. To the extent that wellness programs target health or risk factors that occur disproportionately among women (such as obesity) or racial minorities (such as hypertension) or older workers (such as high serum cholesterol), would employer-sponsored wellness programs meet nondiscrimination tests required under these laws, as well?⁸

Conclusion

In 2014, it will continue to be the case that most privately insured people will be covered by employer-sponsored group health plans. In such plans, risk pooling tends to occur more naturally, some key market reforms, such as nondiscrimination, have long been in place, and employer premium contributions help stabilize risk pools by making coverage affordable for most participants. Under the new proposed wellness regulation, however, a key exception to the nondiscrimination rule would be allowed in order to further another goal – that of promoting personal health responsibility and wellness. How these exceptions are ultimately implemented could have significant implications for the affordability of coverage for people who are older or in poorer health.

⁸ For additional information on the incidence of health conditions by age, sex, gender, and race, see US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "Health, United States, 2011" Available at <http://www.cdc.gov/nchs/data/hus/hus11.pdf>