The ERISA Industry Committee

Testimony before the Equal Employment Opportunity Commission on Voluntary Workplace Wellness Programs

Testimony of Amy Moore
Covington & Burling LLP
on behalf of The ERISA Industry Committee
May 8, 2013
Washington, D.C.

The ERISA Industry Committee
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Advocating the Employee Benefit and Compensation Interests of America's Major Employers

Good morning. My name is Amy Moore. I am a partner at the law firm of Covington & Burling LLP, and I appear before you today on behalf of the ERISA Industry Committee—also known as "ERIC." ERIC is a nonprofit association committed to the advancement of the employee retirement, health, and other welfare benefits of America's largest employers.

ERIC's members sponsor some of the largest private group health plans in the country. These plans provide health care to millions of workers and their families. The great majority of ERIC's members also provide wellness programs for their workers.

ERIC appreciates the opportunity to testify before you and share our concerns about the significant challenges facing workplace wellness programs.

The Importance of Workplace Wellness Programs

The promotion of wellness for every American worker—and every worker's family—has become of paramount importance. An effective workplace wellness program is one of the few programs that can reduce future health care costs while simultaneously providing tangible benefits to employees and employers alike.

Employers benefit when effective workplace wellness programs improve the health of their work force.[1] Workplace wellness programs have proved effective in containing health costs, reducing disability claims, and improving workers' productivity. In addition to these measurable benefits, wellness programs improve the quality of life for American workers and their families by promoting healthy lifestyles. [2] Employees value these programs, and they benefit from the programs' emphasis on promoting good health and addressing health problems before the problems become more serious and more costly to treat.

Congress has repeatedly expressed strong support for wellness programs. For example, the Affordable Care Act ("ACA") codifies and expands the regulatory exemption for workplace wellness programs that include health-related standards. In recognition of the value and effectiveness of wellness programs, ACA includes "wellness services and chronic disease management" among the essential health benefits required for plans offered through health care exchanges. In order to promote workplace wellness programs, ACA directs the Secretary of Health and Human Services to award grants to small employers to provide their employees with access to comprehensive workplace wellness programs. ACA also amends the Medicare program to provide an annual wellness visit and critical preventive screenings at no cost to Medicare beneficiaries.

Members of the Administration, including the President himself, have publicly recognized the value of wellness programs and the importance of incentives as part of these programs. In fact, the President's Fiscal Year 2014 budget would give the Office of Personnel Management authority in

[1] Ross DeVol & Armen Bedroussian, An Unhealthy America 131-32 (Milken Institute Oct. 2007) (estimating $1B annually in lost employee productivity due to reduced performance and missed workdays related to chronic disease), *available at* http://www.milkeninstitute.org/pdf/chronic_disease_report.pdf.

[2] Vicki S. Conn et al., *Meta-Analysis of Workplace Physical Activity Interventions*, 37 Am. J. Preventative Med. 330, 333-34 (2009) (surveying wellness program studies and finding statistically significant improvement in fitness, diabetes risk and participant-reported quality of life and mood for certain studies), *available at* http://www.ajpmonline.org/article/S0749-3797(09)00413-9/.

the Federal Employee Health Benefits Program to make adjustments to premiums based on an enrollee's tobacco use or participation in a wellness program.

The Key Role of Incentives

Three federal nondiscrimination statutes potentially apply to workplace wellness programs: the Health Insurance Portability and Accountability Act ("HIPAA"), which prohibits employer-sponsored group health plans from discriminating against an employee on the basis of the employee's (or a family member's) adverse health factors; the Americans with Disabilities Act ("ADA"), which prohibits discrimination against a qualified individual with a disability in any aspect of employment; and the Genetic Information Nondiscrimination Act ("GINA"), which prohibits health plans, health insurers, and employers from discriminating on the basis of genetic information.

ERIC's members are committed to maintaining a nondiscriminatory workplace. ERIC strongly supports the Commission's goal to prevent discrimination in any aspect of employment, including compensation and benefit programs. ERIC believes that workplace wellness programs are fully compatible with this goal. At present, however, employers struggle to develop and maintain these programs in the face of rules that are often unclear or inconsistent, and sometimes unnecessarily restrictive. The need for clear and consistent guidance is especially acute in the case of incentive-based wellness programs.

Increasing participation in wellness programs is a top priority for employers.[3] To this end, employers are seeking to change workplace cultures, increase employee awareness, and make wellness programs more attractive to their workers. Employers are also turning to another critical tool for increasing employees' achievement of wellness objectives: economic incentives.[4]

Current research shows that rewarding employees for participating in wellness programs and adhering to healthy lifestyles is an effective strategy.[5] The experience of ERIC's members bears out this observation: employees are more likely to participate in wellness programs, and are more likely to persist in healthy behavior, when they are offered economic incentives to do so. ERIC members believe that continued expansion of incentive-based wellness programs will demonstrate the effectiveness of these programs over the long term, and will prove mutually beneficial to both employers and employees.

ERIC urges the Commission to make clear that incentive-based wellness programs are permissible. In particular, ERIC urges the Commission to address the following issues in regulations or other published guidance:

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[3] Aon Hewitt, 2012 Health Care Survey, 8 (2012), *available at* http://www.aon.com/attachments/human-capital-consulting/2012_Health_Care_Survey_final.pdf (70% of employers want to increase wellness program utilization).

[4] HERO, ACOEM, ACS, American Diabetes Association & AHA, *Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives*, 54 J. Occupational & Envtl. Med. 889, 889 (July 2012), *available at* http://journals.lww.com/joem/Abstract/2012/07000; *see also* Aon Hewitt, *supra* note 1, at 33 (from 2011 to 2012, use of financial incentives increased from increase 17% to 54% in disease management programs and from 37% to 59% in health improvement programs).

[5] Soeren Mattke et al., RAND Corporation, A Review of Workplace Wellness Programs, 32 (July 2012); *see also* Employee Benefit Research Institute, Issue Brief No. 379: Findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey, 11 (Dec. 2012), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2012_No379_CEHCS2.pdf ("[B]etween about 60 percent and 80 percent of participants said they would participate in wellness programs if there was some type of financial incentive to do so.").

- Make clear that wellness incentives do not violate the ADA.

- Revise current regulations under GINA to allow employers to offer incentives to provide family medical history.

- Make clear that employers may offer incentives to encourage employees' spouses to provide information about the spouses' own medical history.

1. Make clear that wellness incentives do not violate the ADA.

The Americans With Disabilities Act imposes strict limits on the circumstances in which an employer may require medical examinations or gather medical information about current or prospective employees. The ADA permits employers to offer voluntary medical examinations or request voluntary medical histories as long as they keep the information confidential and do not use it for discriminatory purposes. The Commission issued enforcement guidance in 2000 stating that voluntary wellness programs can qualify for this exception. The enforcement guidance explains that a wellness program is "voluntary" as long as an employer neither requires participation nor "penalizes" employees who do not participate; but the guidance does not explain whether withholding an incentive is viewed as a "penalty" for this purpose.

Regulations issued in 2006 make clear that a workplace wellness program will not violate HIPAA's nondiscrimination requirement as long as the program meets certain conditions. Among other requirements, the program must ensure that the incentive for meeting a health-related standard does not exceed 20 percent of the annual cost of coverage. The incentive limit is designed to ensure that the wellness program is voluntary by prohibiting incentives so large "as to have the effect of denying coverage or creating too heavy a financial penalty on individuals who do not satisfy an initial wellness program standard that is related to a health factor."[6] ACA raises the incentive limit to 30 percent of the cost of coverage and authorizes the Departments of Treasury, Labor, and HHS to raise the limit to 50 percent if they determine such an increase is appropriate. The Departments proposed regulations last November that implement the increased incentive limit and permit employers to provide an incentive up to 50% of the annual cost of coverage to discourage tobacco use.

The Commission's Office of Legal Counsel issued an opinion letter in January 2009 confirming the common-sense view that programs designed to meet the HIPAA standard for voluntary wellness programs also will meet the ADA standard. In March 2009, however, the Commission's Office of Legal Counsel withdrew this portion of its opinion letter. Members of the Commission's legal staff now warn that a workplace wellness program might violate the ADA even if the program fully complies with the ACA/HIPAA limit on incentives and other HIPAA requirements. The Office of Legal Counsel issued an informal discussion letter on January 18, 2013, stating, "The 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."

[6] 71 Fed. Reg. 75,018 (Dec. 13, 2006).

The absence of guidance from the Commission on this point prevents the development of new incentive-based wellness programs and threatens the continuation of existing programs. Congress has not only endorsed, but actually expanded, the standard developed in the HIPAA regulations to ensure that a wellness incentive is not so great as to prevent the program from being voluntary. The HIPAA guidance does not distinguish between incentives that are offered as "rewards" and those that are presented as "penalties": instead, the regulations recognize that providing a reward (such as a discount on the basic health premium) and imposing a penalty (such as a surcharge on the basic health premium) are economically equivalent, and that employers should be permitted to use whichever form of presentation is more effective for their work force. There is no reason to think that different standards should apply under the ADA.

Since Congress has determined that an incentive up to 30 percent of the annual cost of coverage does not prevent a wellness program from being voluntary for purposes of HIPAA, the Commission should acknowledge that the same incentive does not prevent a wellness program from being voluntary for purposes of the ADA. The Commission should also confirm that an incentive is permissible under the ADA regardless of whether it is presented as a reward or as a penalty. ERIC urges the Commission to issue a regulation or other guidance on which employers can rely, as soon as possible, making clear that a wellness program operated in compliance with the HIPAA standards also will satisfy the ADA.

2. Revise the GINA regulations to allow employers to offer employees an incentive to provide family medical history.

Many of the most effective wellness programs are tailored to address each participant's personal health needs. These programs begin by asking the individual to complete a "health risk assessment" that evaluates the individual's health status and identifies any conditions or lifestyle choices that merit further attention. A health risk assessment provides targeted individual health information that increases the participant's awareness of health risks. The wellness program then helps the participant find ways to manage or reduce his or her personal health risks. Because the health risk assessment is a key part of a wellness program's success, many employers offer incentives to encourage their employees to complete the assessment.

The Commission's final regulation interpreting Title II of GINA takes the position that an employer is prohibited from offering *any* financial incentive for an employee to provide genetic information, including family medical history. In order to comply with this requirement, ERIC's members either have removed questions about family medical history from their health risk assessments or have made it clear that employees will receive incentives regardless of whether they answer these questions. As a result, employees are effectively discouraged from procuring and providing family medical history, information that often provides a very significant window into an individual's health risk factors, both present and future.

ERIC strongly disagrees with this interpretation of Title II of GINA, and with similar interpretation of Title I of GINA in regulations issued by the Departments of Labor, Treasury, and HHS. The Commission has offered no explanation why Title II of GINA prohibits an employer from offering an employee a reasonable incentive to provide family medical history or other genetic information that will be held in confidence and used solely for the employee's benefit, other than to say in the preamble of the regulation that this interpretation resulted from "balancing" the benefits of wellness programs "with the need to construe exceptions to the prohibition of acquisition of genetic information in a manner appropriately tailored to their specific purposes." ERIC believes that the

Commission's interpretation has undermined the effectiveness of health risk assessments, depriving workers and their families of a valuable tool for improving their health, and contributing to health care cost inflation.

ERIC urges the Commission to reconsider its earlier interpretation of Title II of GINA. The Centers for Medicare and Medicaid Services ("CMS") has cited extensive literature demonstrating that financial incentives are necessary to encourage individuals to participate in wellness activities, even when their own health is at stake.[7] Employers do not use genetic information gathered through health risk assessments for discriminatory purposes: in fact, Title II of GINA and the Commission's regulation protect the confidentiality of the information and strictly prohibit any discriminatory use. The government's current interpretation of GINA, which prohibits an employer from offering employees a financial incentive to provide family medical history in a health risk assessment, is not necessary to carry out the purposes of GINA, and it severely impairs the effectiveness of workplace wellness programs.

3. Make clear that spousal incentives are permissible.

Large employers provide group health coverage not only to their employees, but also to the employees' family members. Employers wish to promote a healthy lifestyle and to address health risks for all of the individuals covered by the employer's health plan. Individuals are more likely to make positive changes in their health and lifestyle if more than one family member is involved in the wellness program. As a result, it is increasingly common for employers to extend workplace wellness programs to employees' spouses.

A spouse who participates in a workplace wellness program often receives an incentive to complete a health risk assessment. The health risk assessment asks questions about the spouse's health conditions and lifestyle. Although the extension of workplace wellness programs to an employee's spouse is a positive development, ERIC's members have become concerned that the Commission will interpret Title II of GINA to prohibit spousal incentives.

A leading provider of health management and wellness services issued a memorandum in 2011 alerting its clients that the Commission had initiated enforcement action against "a number of employers providing incentives to employees for spouse participation in a health assessment." The provider explained that the spouse's personal medical history was family medical history with respect to the employee, so that the spouse's personal medical history fell under the broad definition of "genetic information" in Title II of GINA. The provider cautioned, "We have been advised that the Commission deems the use of incentives to induce spouses to complete [a health assessment] to be a violation of GINA."

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[7] Centers for Medicare and Medicaid Services, Center for Strategic Planning, Patient Protection and Affordable Care Act Section 4108: Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Initial Announcement at p. 5 (Feb. 23, 2011), available at http://www.cms.gov/MIPCD/Downloads/HHS_ACA_S4108_Solicitation.pdf, citing Kane, Robert L., MD; Johnson, Paul E., PhD; Town, Robert J., PhD and Butler, Mary, MBA, A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior, Am. J. Prev. Med. 2004; 27(4):327–52; see also Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid (Final Report Feb. 3, 2011), available at http://www.cms.gov/MIPCD/Downloads/CMSMedicaidIncentivesGuidance.pdf (report of technical experts advising CMS).

Although neither the Commission's staff nor ERIC's members are aware of a situation in which the Commission has pursued an enforcement action against an employer on this basis, the concern, once raised, has persisted. Because the provider's memorandum reached a number of employers, the issue has created significant confusion and uncertainty. Employers are concerned that they will violate GINA by offering incentives for spouses to complete health risk assessments, and they are uncertain how to structure spousal participation in their wellness programs without violating GINA. If employers are forced to remove spousal incentives from their workplace wellness programs in order to avoid the risk of enforcement action, the effectiveness of the programs will be diminished.

As explained earlier in this testimony, ERIC believes that Title II of GINA should not prohibit a wellness program from offering an incentive for an individual to provide his or her family medical history. Even under the more restrictive rule in the Commission's current regulation, however, Title II of GINA cannot reasonably be interpreted to prohibit incentives for an individual—whether an employee or a spouse—to provide his or her *own* medical history. Every person's own medical history is "family medical history" (and therefore, by definition, genetic information) with respect to the person's relatives. If the restriction on collecting family medical history is extended to an individual's decision to provide his or her own medical history, no employer would be able to request information about an employee's manifested health conditions unless the employee had no living relative. This interpretation cannot be correct.

Title II of GINA allows employers to offer incentives that encourage spouses to provide their own health information, as long as the employer protects the information from disclosure and uses the information only in a manner that is permissible under GINA. ERIC believes that the Commission's current regulation interpreting Title II of GINA support this view.[8] ERIC urges the Commission to issue guidance clarifying this point.

Guiding Employees Into Disease Management Programs

Workplace wellness programs improve employees' health outcomes in part because of their ability to identify individuals who would benefit from participation. The family medical history that an employee voluntarily provides plays an important part in the success of these programs. For example, individuals who are at risk of developing heart disease might be eligible for a disease management program that seeks to prevent or delay the onset of the disease through diet, exercise, monitoring cholesterol levels, and other interventions.

If a participant's voluntary health risk assessment discloses a family history of heart disease, a health professional might contact the participant, provide information about the plan's voluntary disease management program for those at risk of developing heart disease, and recommend that the individual consider participating in the program. The same disease management program would be available to employees who do not have (or who have not disclosed) a family history of heart disease, but who have clinical signs of heart disease or who are at increased risk of developing heart disease because they smoke or have high blood pressure.

[8] ERIC submitted a letter to Commissioners Feldblum and Lipnic on February 17, 2012, explaining the analysis that supports this conclusion. A copy of the letter is attached to this testimony.

The Commission's regulation interpreting Title II of GINA makes clear that an employer may use the genetic information an employee voluntarily provides to guide the employee into an appropriate disease management program, provided that employees may also qualify for the program without providing genetic information. The regulation states:

> A covered entity may offer financial inducements to encourage individuals who have voluntarily provided genetic information that indicates that 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.[9]

The preamble of the Commission's regulation interpreting Title II of GINA states that Title I of GINA, which applies to group health plans, contains a parallel rule.[10] According to this statement, a group health plan may offer an employee incentives to participate in a disease management program based on an increased risk disclosed in the employee's voluntary family medical history, provided that the incentives to participate in the disease management program are also available "to individuals who qualify for the program but have not volunteered genetic information through a [health risk assessment]."In fact, however, an example in the regulation interpreting Title I of GINA appears to illustrate precisely the opposite rule.[11] The example describes a situation in which a group health plan requests that an employee complete a health risk assessment after enrollment. The health risk assessment includes questions about the individual's family medical history, but the plan does not offer the employee any incentive to complete the health risk assessment. Employees who voluntarily provide family medical history may qualify for a disease management program based on risks disclosed in the family medical history; employees who do not provide family medical history also may qualify for the disease management program based on their own health conditions. Accordingly, family medical history is *one* basis (but not the *only* basis) for determining an employee's eligibility to participate in the disease management program.

Although the GINA Title II regulation identifies this situation as a permissible use of family medical history, the example in the Title I regulation states that the same use of family medical history constitutes impermissible underwriting. The Title I example explains:

> [C]ertain people completing the health risk assessment may become eligible for additional benefits under the plan by being enrolled in a disease management program based on their answers to questions about family medical history. Other people may become eligible for the disease management program based solely on their answers to questions about their individual medical history.

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[9] 29 C.F.R. § 1635.8(b)(2)(iii).

[10] 75 Fed. Reg. at 68,924 (Nov. 9, 2010).

[11] Treas. Reg. § 54.9802-3T(d)(3) *Example 4*; 29 C.F.R. § 2590.702-1(d)(3) *Example 4*; 45 C.F.R. § 146.122(d)(3) *Example 4.*

(ii) *Conclusion*. In this Example 4, the request for information about an individual's family medical history could result in the individual being eligible for benefits for which the individual would not otherwise be eligible. Therefore, the questions about family medical history on the health risk assessment are a request for genetic information for underwriting purposes and are prohibited under this paragraph (d). Although the plan conditions eligibility for the disease management program based on determinations of medical appropriateness, the exception for determinations of medical appropriateness does not apply because the individual is not seeking benefits.

This example appears to illustrate the principle that a group health plan *may not* use voluntary family medical history to guide employees into appropriate disease management programs, and may not offer employees incentives to participate in the programs, unless the employees "seek" admission to the programs on their own initiative. Instead, the group health plan may do no more than publicize the disease management program to all participants and hope that the individuals who might benefit will identify themselves, understand on their own the importance of the program to their continued health, and apply for admission.

Nothing in Title I of GINA requires this result. As the Title I regulation recognizes, GINA permits a group health plan to use genetic information to determine whether a benefit or service is medically appropriate. Accordingly, a group health plan should be permitted to use genetic information as one way to determine whether an individual is eligible to participate in a disease management program, as long as the plan does not restrict participation to employees who provide family medical history.

The only difference between conduct prohibited and conduct permitted under the Title I regulation is a question of timing. If the plan uses genetic information on its own initiative to determine whether the participant is eligible for the disease management program, the plan's use of genetic information is prohibited. In contrast, if the plan waits until the participant applies for admission to the disease management program and then uses genetic information to determine whether the participant is eligible, the plan's use of genetic information is permitted. This artificial distinction bears no relationship to the concept of "underwriting."

Experience has shown that without the encouragement of a health professional, many participants who would benefit from participation in a disease management program will never enroll. Accordingly, the position taken in the Title I regulation is not only unnecessary, it is potentially damaging to the health of plan participants. ERIC believes that the rule stated in the Title II regulation is correct and should be maintained. ERIC urges the Commission to coordinate this position with that of the Departments of Labor, Treasury, and HHS to make clear that a plan will not be deemed to collect genetic information for "underwriting purposes" when the plan uses family medical history provided voluntarily as one basis to identify participants eligible for a disease management program or similar voluntary program.

The Need for Guidance That Recognizes the Value of Wellness Programs

A strong consensus is emerging within the Administration as well as from the plan sponsor and provider communities that workplace wellness programs are a critical component of the nation's

efforts to reduce chronic health problems and control health costs. Future regulations and other guidance should emphasize ways in which workplace wellness programs may more successfully encourage participants and their families to pursue healthier choices and achieve healthier lifestyles. The Commission, in conjunction with the other regulators, should develop rules that will enable employers to continue their existing programs and develop new, more effective approaches.

Employers devote substantial time and resources to developing effective workplace wellness programs, training internal staff and outside vendors to administer the programs properly, and communicating the programs to their employees. In the aggregate, the wellness programs sponsored by ERIC's members cover hundreds of thousands of employees and their family members. These programs often cover individuals who work and live in many different states.

Accordingly, regardless of how the Commission approaches the substantive issues affecting wellness programs, it is important that the Commission provide clear, consistent published guidance on which employers may rely. Employers should not be subject to the interpretations and enforcement initiatives of the Commission's regional offices as the employers develop and administer their wellness programs for a nationwide work force. To the extent that future guidance imposes new restrictions on workplace wellness programs, the guidance should be effective only prospectively, with ample time for implementation, so that employers will not be penalized for failing to comply with a restriction they could not have foreseen.

Wellness programs are one of the few tools that can help rein in runaway health care costs. It would be counterproductive from a cost-containment perspective, as well as from the standpoint of improving Americans' health, if future guidance were to limit the effectiveness of workplace wellness programs. We look forward to working with the Commission to develop rules that will protect workers from discrimination while they give employers the freedom to develop programs that can address the serious health problems of workers and their families.

Thank you for providing us with this opportunity to testify. We would be pleased to respond to any questions you might have.

ERIC

The ERISA Industry Committee

ERIC Comment Letter to EEOC on February 17, 2012

February 17, 2012

Chair. Feldblum, Commissioner
Victoria A. Lipnic, Commissioner
Equal Employment Opportunity Commission
131 M Street, N.E.
Washington, DC 20507

Re: Permitting Spousal Incentives in Workplace Wellness Programs

Dear Commissioners Feldblum and Lipnic:

We very much appreciate your meeting with members and representatives of The ERISA Industry Committee ("ERIC") on November 30, 2011 to discuss workplace wellness programs and the important role these programs play in improving the health of American workers and families.

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, and welfare benefit plans of America's largest employers. ERIC's members sponsor group health plans that provide comprehensive health benefits directly to some 25 million active and retired workers and their families. ERIC members have taken the lead in developing wellness programs that have significantly improved the health of their employees.

As we discussed during our meeting, many large employers extend workplace wellness programs to an employee's spouse. Although this is a positive development, ERIC's members have become concerned that recent action by the Equal Employment Opportunity Commission could jeopardize employers' efforts to promote the health of spouses in addition to that of the employees themselves.

Specifically, ERIC members have received reports that the Commission is taking enforcement action against employers that offer incentives to encourage spouses to complete health risk assessments, on the ground that the spousal incentives violate Title II of the Genetic Information Nondiscrimination Act ("GINA"). As you requested, we are writing to explain why we think spousal incentives are consistent with the purposes of the statute and are permissible under the Commission's regulation interpreting Title II of GINA.

The Importance of Incentives in Wellness Programs

Workplace wellness programs have a central role to play in the Administration's efforts to improve the health of American workers. Moreover, workplace wellness programs have proved effective in containing health costs, reducing disability claims, and improving workers' productivity.

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In addition to these measurable benefits, wellness programs improve the quality of life for American workers and their families by promoting healthy lifestyles. Employees value these programs, and they benefit from the programs' emphasis on promoting good health and addressing health problems before the problems become more serious and more costly to treat.

Many of the most effective wellness programs are tailored to address each participant's personal health needs. These programs begin by asking the individual to complete a "health risk assessment" that evaluates the individual's health status and identifies any conditions or lifestyle choices that merit further attention. A health risk assessment provides targeted individual health information that increases the participant's awareness of health risks. The wellness program then helps the participant find ways to manage or reduce his or her personal health risks.

Because the health risk assessment is a key part of a wellness program's success, many employers offer incentives to encourage their employees to complete the assessment. The incentives might include items such as a small cash bonus, a gift card, or a health club pass. Employers have found that employees are much more likely to complete a health risk assessment if they receive a modest incentive, and studies have confirmed this observation. For example, a 2011 survey showed that 28 percent of employees completed a health risk assessment if the employer offered no incentive, but participation increased to 48 percent when the employer offered an incentive.[1]

The use of incentives has been restricted by recent governmental regulations, however, and these restrictions have made it more difficult for employers to encourage participation in workplace wellness programs. As an example, the Commission's regulation interpreting Title II of GINA prohibits an employer from conditioning an incentive on the employee's agreement to provide family medical history.[2] In order to comply with this requirement, ERIC's members either have removed questions about family medical history from their health risk assessments or have made it clear that employees will receive incentives regardless of whether they answer these questions. As a result, employees are effectively discouraged from procuring and providing family medical history, information that often provides a very significant window into an individual's health risk factors, both present and future.

Large employers provide group health coverage not only to their employees, but also to the employees' family members. Employers wish to promote a healthy lifestyle and to address health risks for all of the individuals covered by the employer's health plan. In addition, individuals are more likely to make positive changes in their health and lifestyle if more than one family member is involved in the wellness program. As a result, it is increasingly common for employers to extend workplace wellness programs to employees' spouses and domestic partners.

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[1] *See* PricewaterhouseCoopers Health and Well-Being Touchstone Survey at 42-43 (May 2011), http://www.pwc.com/us/en/hr-management/publications/health-wellness-touchstone-survey.jhtml.

[2] C.F.R. §1635.8(b)(2)(ii). The regulations interpreting Title I of GINA include similar restrictions. *See* Treas. Reg. § 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).

A spouse who participates in a workplace wellness program often receives an incentive to complete a health risk assessment. The health risk assessment asks questions about the spouse's health conditions and lifestyle. The wellness program treats the spouse in the same way that it treats the employee: the program does not offer an incentive for the spouse to provide the spouse's family medical history or other genetic information about the spouse, although the program might invite the spouse to provide this information voluntarily without receiving an incentive.

Some wellness programs offer the incentive separately to the employee and to the spouse, so that each could receive an incentive if he or she completes the health risk assessment. Other programs provide an incentive only if both the employee and the spouse complete a health risk assessment. In either case, if the spousal incentive is provided in the form of a cash bonus or other taxable benefit, federal tax rules treat the incentive as compensation to the employee, and the employer reports the incentive on the employee's Form W-2.[3]

Employers Need Guidance Concerning Spousal Incentives

Last fall, a leading provider of health management and wellness services issued a memorandum alerting its clients that the Commission had initiated enforcement action against "a number of employers providing incentives to employees for spouse participation in a health assessment." The provider explained that the spouse's personal medical history was family medical history with respect to the employee, so that the spouse's personal medical history fell under the broad definition of "genetic information" in Title II of GINA.[4] The provider cautioned, "We have been advised that the Commission deems the use of incentives to induce spouses to complete [a health assessment] to be a violation of GINA."

ERIC has not been able to determine how many employers were affected by these enforcement actions, which local office of the Commission was involved, or how the enforcement actions were resolved. Because the provider's memorandum reached a number of large employers, however, the issue has created significant confusion and uncertainty. Employers are concerned that they will violate GINA by offering incentives for spouses to complete health risk assessments, and they are uncertain how to structure spousal participation in their wellness programs without violating GINA.

We urge the Commission to provide national guidance on this issue, so that the rules will be clear and evenly enforced. Employers devote substantial time and resources to developing effective workplace wellness programs, training internal staff and outside vendors to administer

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[3] *See* Internal Revenue Code § 83 (when an employer transfers property to any third person in connection with an employee's services, the value of the property is included in the employee's gross income); Treas. Reg. § 1.61-21(a)(3) (a "fringe benefit provided in connection with the performance of services [is] considered to have been provided as compensation for such services"); Treas. Reg. § 1.61-21(a)(4) (a taxable fringe benefit is included in the income of the person performing the services, even if that person did not actually receive the fringe benefit).

[4] *See* 29 C.F.R. § 1635.3(c)(1)(iii) (defining "genetic information" to include information about "[t]he manifestation of disease or disorder in family members of the individual (family medical history)").

the programs properly, and communicating the programs to their employees. In the aggregate, the wellness programs sponsored by ERIC's members cover hundreds of thousands of employees and their family members. If employers are forced to remove spousal incentives from their workplace wellness programs in order to avoid the risk of enforcement action, the effectiveness of the programs will be diminished.

As we explain below, the reported enforcement actions appear to be contrary to the Commission's regulation interpreting Title II of GINA. Regardless of how the Commission resolves the substantive issue, however, any interpretation of GINA that significantly affects workplace wellness programs should be provided in the form of published guidance and should reflect the considered position of the Commission rather than the enforcement initiative of a local office. Any guidance restricting or prohibiting spousal incentives should be effective only prospectively, with ample time for implementation, so that employers will not be penalized for failing to comply with a restriction they could not have foreseen.

Title II of GINA Permits Spousal Incentives

For the reasons we explain below, we think that Title II of GINA allows employers to offer incentives that encourage spouses to provide their own health information, as long as the employer protects the information from disclosure and uses the information only in a manner that is permissible under GINA. Three provisions in the Commission's regulation interpreting Title II of GINA support this view: the rule that allows an employer to acquire information about manifested health conditions, the exception for voluntary wellness programs, and the rule that permits an employer to acquire information about family members who receive health services from the employer. We discuss each provision below.

A. Employers May Acquire Information About Manifested Conditions

Section 202(b) of GINA prohibits an employer from acquiring genetic information "with respect to an employee or a family member of the employee" unless an exception applies. The regulation interpreting Title II of GINA defines "family member" to include an individual's spouse, as well as the individual's natural and adopted children and relatives to the fourth degree.[5] "Genetic information" includes, with respect to any individual, information about "[t]he manifestation of disease or disorder in family members of the individual (family medical history)."[6] Accordingly, the regulation treats as "genetic information" not only the family medical history of the employee, but also the family medical history of any family member of the employee.

If one construes these provisions broadly, they create a paradox. Information about an employee's own manifested health conditions is family medical history—and thus is "genetic information"—with respect to *any* family member of the employee. Since an employer is prohibited from acquiring genetic information about a family member of an employee, a broad

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[5] 29 C.F.R. § 1635.3(a); *see also* GINA § 201(3).

[6] 29 C.F.R. § 1635.3(c)(1)(iii); *see also* GINA § 201(4)(A)(iii).

interpretation of this restriction would prohibit the employer from acquiring information about any manifested health condition of the employee unless the employee had no living relative who qualified as a "family member."[7] This interpretation cannot be correct: it would place an unworkable constraint on an employer's ability to request information about an employee's own manifested health conditions.

The Commission's regulation interpreting Title II of GINA recognizes this problem and provides a solution, although in a narrower context. One comment on the proposed regulation raised a concern that an employer would violate GINA if the employer obtained information about a manifested disease or disorder of an employee whose family member worked for the same employer, since the personal medical history of the first employee would constitute family medical history with respect to the second employee.[8] In response, the final regulation confirms that an employer does not violate GINA solely because the employer "requests, requires, or purchases information about a manifested disease, disorder, or pathological condition of an employee . . . whose family member is an employee for the same employer."[9]

The final regulation presents the co-employee provision not as an exception to the restriction on acquiring genetic information,[10] but as a general principle of interpretation. Although the regulation addresses a situation in which both members of the family work for the same employer, the rationale for the rule is not limited to this situation. As we have explained, information about an employee's manifested health conditions is "genetic information" with respect to any family member of the employee, whether or not the family member works for the same employer. Accordingly, the rule will be workable only if it is construed as an illustration of a broader principle: the principle that GINA does not prohibit an employer from requesting information about an individual's own manifested health conditions, even though that information constitutes family medical history with respect to the family members of the individual who provides the information.

The preamble to the final regulation describes this provision in broad terms as a rule that permits an employer to acquire information about an employee's manifested conditions in all circumstances, whether or not the employee's family members work for the employer. In the preamble, the Commission explained:

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[7] Section 210 of GINA permits an employer to acquire "information *that is not genetic information* about a manifested disease, disorder, or pathological condition of an employee . . . " (emphasis added). This exception suffers from the same internal contradiction, however, since information about an employee's manifested health condition is genetic information if the employee has any living family member.

[8] 75 Fed. Reg. 68,912, 68,915 (Nov. 9, 2010).

[9] 29 C.F.R. § 1635.8(c)(1).

[10] All of the exceptions to the rule prohibiting an employer from acquiring genetic information appear in subsection 8, paragraph (b) of the regulation. *See* 29 C.F.R. § 1635.8(a) (an employer may not acquire genetic information "except as specifically provided in paragraph (b) of this section"). In contrast, the provisions concerning co-employees, and a similar provision (discussed below) concerning health services provided to family members, appear in paragraph (c) of the regulation.

> Although the acquisition of information about manifested conditions is limited under other laws such as the ADA, it is permissible under GINA, *even where* an employee's family member works for the same employer.[11]

Accordingly, the co-employee provision stands for the proposition that GINA does not prohibit an employer from acquiring information about an individual's manifested health conditions, since that information is not "genetic information" with respect to the individual who provides it.[12] If GINA does not prohibit an employer from acquiring information from an employee about the employee's manifested health conditions, there is even less reason to think that GINA prohibits an employer from acquiring information from an employee's spouse about the spouse's manifested health conditions.[13]

Because information about an individual's manifested health conditions is family medical history with respect to the individual's family members, the employer must treat the information as "genetic information" once the employer acquires it. The employer may not use the information to discriminate against an employee and may not disclose the information except as permitted by the regulation.[14] These restrictions apply to information acquired from an employee's spouse in a health risk assessment. Accordingly, although Title II of GINA does not prohibit an employer from requesting information from a spouse about the spouse's own health conditions, Title II of GINA fully protects the employee from any misuse of this information.

B. The Exception for Voluntary Wellness Programs Applies to Spouses

Although Title II of GINA generally prohibits an employer from acquiring genetic information with respect to an employee or the employee's family member, the statute creates several exceptions to this restriction. One exception applies in a case where "health or genetic services are offered by the employer, including such services offered as part of a wellness program."[15] The regulation interpreting Title II of GINA incorporates this exception. Unlike the statute, however, the regulation requires that the wellness program be a "voluntary" wellness

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[11] 75 Fed. Reg. at 68,916 (emphasis added); *see also* Preamble, 75 Fed. Reg. at 68,926 ("[A] request for information about whether an individual has a manifested disease, disorder, or pathological condition does not violate GINA simply because a family member of the individual to whom the request was made works for the same employer . . .").

[12] Although we have not discussed Title I of GINA in this letter, we believe that the same concept is implicit in the interpretation of Title I by Departments of Treasury, Labor, and Health and Human Services. For example, the interim final regulation interpreting Title I includes an example in which an employer is permitted to provide a financial incentive when an individual completes a health risk assessment that "instructs the individual to answer only for the individual and not for the individual's family." Treas. Reg. § 54.9802-3T(d)(3) *Example 5*; 29 C.F.R. § 2590.702-1(d)(3) *Example 5*; 45 C.F.R. § 146.122(d)(3) *Example 5*. Accordingly, we believe that an incentive to a spouse to provide information about the spouse's own manifested health conditions is permissible under Title I of GINA as well as under Title II.

[13] As we explain below, the regulation at 29 C.F.R. § 1635.8(c)(2) confirms this interpretation.

[14] *See* Preamble, 75 Fed. Reg. at 68,915-16 & 68,926.

[15] GINA § 202(b)(2).

program. The regulation explains that the program is voluntary only if it "neither requires the individual to provide genetic information nor penalizes those who choose not to provide it."[16]

The regulation explains that a wellness program will not fail to be "voluntary" solely because the employer offers a financial inducement for participants to complete a health risk assessment. If the health risk assessment requests family medical history or other genetic information, however, the employer must make clear that the participants will receive the financial inducement whether or not they answer the questions about genetic information. As we explained in the preceding section, "genetic information" means, in this context, information that is genetic information with respect to the individual who completes the health risk assessment, such as the individual's family medical history. The term does not include information about the individual's own manifested health conditions, even though that information is "genetic information" with respect to the individual's family members. Any other interpretation would make the exception meaningless, since the purpose of a health risk assessment is to collect and evaluate information about the health conditions of the person who completes the assessment.

Neither the statute nor the regulation limits the exception for voluntary wellness programs to employees. To the contrary, both the statute and the regulation acknowledge that a family member might receive services under the wellness program.[17] Because GINA prohibits an employer from acquiring genetic information about family members as well as about employees, it is logical that the exception also would apply to family members. The regulation adopts this interpretation: it extends the exception to any "individual," a term that is broad enough to include an employee's family member as well as an employee or member of a labor organization. Accordingly, if an employee's spouse receives a financial inducement to provide information about the spouse's own manifested health conditions in response to a health risk assessment, the employer does not violate the restriction on acquiring genetic information, even though the information about the spouse's manifested health conditions is genetic information with respect to the spouse's family members (including the employee).

The exception for voluntary wellness programs applies not only when the employee and spouse receive separate incentives for completing health risk assessments, but also when both members of the couple must complete health risk assessments in order to receive an incentive. In either case, the incentive will be available if the participants provide information concerning their own health conditions and lifestyle choices, which is not genetic information with respect to the individual completing the assessment. The incentive will be available whether or not the participants answer questions about their family medical history or provide other genetic information. The information that each participant provides will be protected from disclosure or improper use. Whether the incentive is provided separately or jointly, the federal tax rules will treat both the employee's and the spouse's incentive as compensation to the employee.[18]

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[16] 29 C.F.R. § 1635.8(b)(2)(i)(A).

[17] GINA § 202(b)(2)(c); 29 C.F.R. § 1635.8(b)(2)(i)(C).

[18] See footnote 3, above.

If the employer offers a joint incentive, each member of the couple will receive the incentive only if the other member of the couple chooses to complete the health risk assessment. Although this incentive structure might increase the likelihood that both members of the couple will participate in the health risk assessment, it does so by providing an additional incentive for each member to provide information about his or her own manifested health conditions. The regulation interpreting Title II of GINA expressly allows an employer to offer a financial inducement to encourage an individual to provide information about the individual's own manifested health conditions. Accordingly, the regulation does not prohibit an employer from offering a joint incentive for an employee and spouse to complete health risk assessments.

C. An Employer May Obtain Information From Family Members Who Receive Health Services

The Commission's final regulation confirms that an employer does not violate Title II of GINA when the employer acquires "genetic information or information about the manifestation of a disease, disorder, or pathological condition" from an employee's family member who "is receiving health or genetic services on a voluntary basis."[19] The preamble of the final regulation explains, "The collection of information about the manifested disease or disorder of a family member in the course of providing health or genetic services to the family member is not an unlawful acquisition of genetic information about the [employee]."[20] Like the provision applicable to co-employees, this provision describes a general principle of interpretation rather than a specific exception under Title II of GINA.[21]

The provision concerning health services provided to family members is consistent with the exception for voluntary wellness programs. The health services provision confirms that an employer does not violate Title II of GINA when it acquires information about a spouse's own manifested health conditions, even though this information constitutes genetic information with respect to the members of the spouse's family, including the employee.

The regulation does not explain what it means for a family member to receive health services "on a voluntary basis." The exception for voluntary wellness programs makes it clear, however, that an employer may offer an employee's spouse a financial inducement to complete a health risk assessment that requests information about the spouse's own manifested health conditions, as long as the spouse is not required to provide the spouse's family medical history or other genetic information in order to receive the incentive.[22] Accordingly, a spouse who receives a financial inducement to complete a health risk assessment that requests information about the spouse's own manifested health conditions is receiving health services "on a voluntary basis."

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[19] 29 C.F.R. § 1635.8(c)(2).

[20] 75 Fed. Reg. at 68,926.

[21] See footnote 10, above, and accompanying text.

[22] 29 C.F.R. § 1635.8(b)(2)(ii); see also the discussion of this point in the preceding section of this letter.

Conclusion

The Commission's regulation interpreting Title II of GINA permits an employer to offer a financial inducement to an employee's spouse to complete a health risk assessment. The regulation makes clear that the employer may condition the incentive on the spouse's willingness to provide information about the spouse's own manifested health conditions, even though this information constitutes genetic information with respect to the employee and other members of the spouse's family.

ERIC members strongly support GINA's goal of preventing discrimination in employment based on genetic information. The Commission's regulation prohibits an employer from disclosing or making improper use of genetic information obtained by any means, including information obtained from a spouse's health risk assessment. The exception for voluntary wellness programs states that this information may not be made available to the employer in a manner that identifies it with a specific employee or spouse. These safeguards ensure that genetic information gathered through workplace wellness programs will be used only for its intended purpose: to prevent disease and improve the health of workers and their families.

We appreciate your willingness to meet with us and to consider these comments on spousal incentives. If additional information would be helpful to you, please let us know. We hope the Commission will issue guidance making clear to its enforcement staff and to employers that spousal incentives offered through a workplace wellness program do not violate Title II of GINA and are consistent with the purposes of the statute.

Sincerely,

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