No. 16-1402

IN THE UNITED STATES COURT OF APPEALS

FOR THE SEVENTH CIRCUIT

Equal Employment Opportunity Commission,

Plaintiff-Appellant,

v.

Flambeau, Inc.,

Defendant-Appellee.

Appeal from the United States District Court
for the Western District of Wisconsin
Case No. 14-638, Hon. Barbara B. Crabb

BRIEF OF THE HR POLICY ASSOCIATION, THE AMERICAN BENEFITS COUNCIL, THE CHAMBER OF COMMERCE OF THE UNITED STATES, AND THE ERISA INDUSTRY COMMITTEE AS *AMICI CURIAE* IN SUPPORT OF AFFIRMING SUMMARY JUDGMENT FOR DEFENDANT-APPELLEE FLAMBEAU, INC.

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The HR Policy Association, The American Benefits Council, The Chamber of Commerce of the United States, and The ERISA Industry Committee.

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CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

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Short Caption: EEOC v. Flambeau, Inc.

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Interest of Amici Curiae

Four organizations – The ERISA Industry Committee, The Chamber of Commerce of the United States of America, The American Benefits Council, and The HR Policy Association – representing varying constituencies – jointly file this brief as they share concerns regarding the regulation of wellness programs, and the consequences thereof on plan sponsors and wellness program participants.

The HR Policy Association represents the most senior human resource executives in more than 360 of the largest corporations doing business in the United States. Collectively, these companies employ more than ten million employees in the United States, nearly nine percent of the private sector workforce. As America's largest employers, HR Policy Association member companies provide health benefits, including wellness programs, to their employees and dependents. Wellness programs are an integral component of HR Policy member companies' self-insured health plans, and such programs play a key role in classifying and administering risk under those plans.

The American Benefits Council is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 400 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly

sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs.

The Chamber of Commerce of the United States of America is the world's largest business federation. It represents 300,000 direct members and indirectly represents the interests of more than 3 million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files amicus curiae briefs in cases that raise issues of concern to the nation's business community.

The ERISA Industry Committee ("ERIC") is the voice of large employer plan sponsors on public policies impacting their ability to provide affordable and cost-effective benefits to millions of active workers, retired persons, and their families nationwide. ERIC is a non-profit organization representing America's largest employers that maintain ERISA-covered pension, healthcare, disability, and other employee benefit plans. ERIC frequently participates as amicus curiae in cases that have potential far-reaching adverse effects on employee benefit plan design or administration.

This case is significant for the employer-members of all of these organizations. Wellness is an important issue for the employer-members because wellness programs improve the health and quality of life of their employees, prevent disease and

premature death, increase productivity, and can reduce healthcare costs for both employees and employers. Wellness programs make health insurance more affordable, and they provide health plans with valuable information from which they can reasonably anticipate future healthcare costs and take those anticipated costs into consideration when designing and pricing the plans. Employers and insurers increasingly have added wellness programs as terms of their health plans because of the numerous benefits described above. These wellness programs, just like all other terms of health plans, are protected by the Americans with Disabilities Act's "safe harbor" for benefits plans.

The Equal Employment Opportunity Commission ("EEOC") argues in this case and in its recently issued regulations[1] that the insurance safe harbor does not apply to wellness programs. EEOC seeks to justify this position with a tortured reading of the Americans with Disabilities Act ("ADA") that is inconsistent with the statute's text, legislative history, and purpose. If accepted, EEOC's position would prevent health plans from maximizing participation in wellness programs, which would eliminate a valuable tool used by health plans to anticipate future costs and would greatly reduce the improved health and cost savings these programs confer on employees, to the detriment of both employees and employers.

[1] *See* 81 Fed. Reg. 31126.

Rule 29(c)(5) Statement

No party or party's counsel authored this brief in whole or part or contributed money intended to fund preparing or submitting it. No person other than *amici curiae*, their members and their counsel contributed money intended to fund preparing or submitting it.

Introduction and Summary of Argument

In this litigation and by regulation, EEOC is attempting to regulate—with no authority to do so—wellness programs that are part of employer-sponsored health benefit plans. While the ADA does contain certain limitations on the circumstances in which employers may request medical information and examinations from employees, these protections do not apply to health plans. The plain language of the ADA contains an insurance safe harbor specifically exempting terms of health plans from the ADA's requirements. Wellness programs like the one in this case that are part of health plans clearly fall within this express safe harbor. The ADA's plain language, its legislative history, and its purpose all make clear that the ADA was *not* intended to interfere with the elements of a health plan so long as the plan was not set up as a subterfuge to take discriminatory employment action against individuals with disabilities. Where, as here, a wellness program is a term of a health plan and is used for underwriting, classifying, and administering risk, the insurance safe harbor applies to the wellness program. The Eleventh Circuit has expressly so held that the safe harbor applied to a wellness program very similar to this one. *Seff v. Broward County*,

778 F. Supp. 2d 1370, 1373 (S.D. Fla. 2011), *aff'd* 691 F.3d 1221 (11th Cir. 2012).

Wellness programs are an important part of many health plans offered by employers not only because they improve employee health and reduce healthcare costs, but also because they can mitigate health risks and provide valuable, aggregate information about the covered population that is used by employers and their healthcare consultants and health plans to underwrite and assess risk. As Flambeau argues, and the district court correctly held, wellness programs that are part of health plans fall within the ADA insurance safe harbor, and EEOC cannot limit wellness programs that are part of bona fide employer group health plans. Otherwise, health plans could only offer wellness programs on a "voluntary" basis, and health plans would be unable to maximize employee participation in their wellness programs, which is critical to their success in identifying and mitigating risks, designing plan benefits to meet employees' needs, and more accurately forecasting future healthcare costs the plans may incur.

The decision below should be affirmed.

Argument

A. Wellness programs are an important part of employer-sponsored health plans that benefit employees.

A majority of large employers that offer health benefits to employees also offer various kinds of wellness programs to promote employee health and productivity, to mitigate health risks, to reduce health related costs, and to use in future plan design

and pricing. *See infra* at 10-11; *see also* Kristen Madison, *Employer Wellness Incentives, the ACA, and the ADA: Reconciling Policy Objectives*, 51 Willamette L. Rev. 407, 412-13 (2015); Karen Pollitz & Matthew Rae, "Workplace Wellness Programs Characteristics and Requirements" (May 19, 2016).[2]

According to a 2015 survey by the Kaiser Family Foundation and Health Research and Annual Trust, 64 percent of large employers offering health benefits also have a wellness program with either a Health Risk Assessment ("HRA") or biometric screening. Pollitz & Rae, *supra*.[3] These programs apply to the 37.5 million employees working for these large employers offering HRAs or biometric screening. *Id.* Over half of the large employers with wellness programs offer these programs through their group health plans. *Id.*

Wellness programs can be structured in a variety of ways. Some wellness programs are limited to screening to identify health risks, typically HRAs or biometric screening. Other wellness programs combine screening with lifestyle management services to reduce risks and encourage healthier behavior. Some wellness programs also include disease management services to support employees who already have chronic conditions. *See id.*; Rachel M. Henke, Ron Z. Goetzel, Janice McHugh & Fik Isaac, *Recent Experience in Health Promotion at Johnson & Johnson: Lower Health Spending,*

[2] Available at http://kff.org/private-insurance/issue-brief/workplace-wellness-programs-characteristics-and-requirements/.

[3] The survey defined a large employer as one with at least 200 employees.

Strong Return on Investment, Health Affairs 30, no. 3 (2011), at 491.

The federal government recently contracted with the RAND Corporation to study workplace wellness programs and analyze their impact on improving health and reducing costs. *See* RAND Health, Workplace Wellness Programs Study: Final Report (2013).[4] According to a RAND survey, most employers offering a wellness program (72 percent) characterize their program as a combination of screening activities and interventions/management services. *Id.* Some employers offer wellness programs directly to employees, while others offer wellness programs through their group health plans to plan members. *Id.* at p. xiv; *see also* Bryan D. LeMoine & Elizabeth T. Gross, *Wellness Programs: Navigating through the Legal and Regulatory Framework*, 55 St. Louis B.J. 10, 10-12 (2009).

RAND found that participants in wellness programs benefitted from "statistically significant and clinically meaningful improvements in exercise frequency, smoking behavior and weight control." 2013 RAND Health, *supra*, at p. xiv. Overall, RAND concluded through its own survey, as well as review of published literature and case studies, that wellness programs have positive effects on a wide variety of health-related behavior and health risks, including increasing smoking cessation, increasing physical activity, increasing fruit and vegetable consumption, decreasing fat intake, and reducing body weight, cholesterol levels, and blood pressure. *Id.* A

[4] Available at https://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf.

separate RAND report also estimated that employer wellness programs have a significant effect on cardiovascular health. Researchers estimated that "[u]nder realistic assumptions for participation, 257 cardiovascular deaths and 1,796 nonfatal cardiovascular events are avoided in 100,000 individuals over 20 years" as a result of participation in wellness programs. *See* RAND Health, Workplace Wellness Programs: Services Offered, Participation, and Incentives (2014).[5] Employer wellness programs quite literally save lives.

B. Group health plans increasingly use wellness programs because they are essential to identifying and mitigating risks, minimizing costs, designing plan benefits, and accurately forecasting risks.

Group health plans are increasingly using wellness programs to identify and mitigate health risks, to reduce healthcare costs, to design plan benefits to meet the needs of employees, and to more accurately forecast future healthcare costs the plans may incur.

First, health plans use wellness programs to assist employees with identifying and mitigating their health risks. Health plans often use the results of HRAs and biometric screening to identify individuals "who may benefit from behavioral modification or disease management programs." *See, e.g.,* RAND Corporation, Workplace Wellness Programs Study: Case Studies Summary Report (April 2013)[6] (noting that at-risk employees may speak with a health coach, call the nurse hotline, or

[5] Available at https://www.dol.gov/ebsa/pdf/wellnessstudyfinal.pdf.

[6] Available at https://www.dol.gov/ebsa/pdf/workplacewellnessstudysummary.pdf.

participate in behavioral modification or disease management programs); *see also* Henke, Goetzel, McHugh & Isaac, *supra*, at 491 (stating that employees are offered "customized programs to address [their] health risks").

Health plans have reported significant success at mitigating health risks by offering targeted wellness services. *See, e.g.*, RAND Corporation, *supra*, at 46 ("70 percent [of the employees who participated in biometric screening] lost weight, 80 percent of individuals with hypertension lowered their blood pressure, and well over half [] (65%) improved their cholesterol levels. Individuals were also likely to improve their health-related behaviors. Approximately half of individuals who completed the biometric screening reported they stopped smoking (53%) and emergency room visits decreased . . . while preventive care visits have increased.").

Second, evidence suggests that wellness programs reduce healthcare costs. *See generally* Elizabeth C. Ghandakly, *Employee Wellness Programs: A Cure For Employer Health Plans?*, 3 Entrepreneurial Bus. L.J. 37, 40 (2008). A 2010 study found a $3.27 drop in medical costs and a $2.73 drop in absenteeism costs for every dollar spent on wellness programs. *See* Katherine Baicker, David Cutler & Zirui Song, *Workplace Wellness Programs Can Generate Savings*, *Health Affairs* 29, no. 2 (2010), at 1. Even greater savings was observed in a case study of the wellness program at Johnson & Johnson. Researchers found that the average annual per employee savings was $565 in 2009 dollars, producing a return on investment equal to a range of $1.88 to $3.92 saved for every dollar spent on the program. *See* Henke, Goetzel, McHugh & Isaac, *supra*, at

490. A 2015 Mercer survey of health plans also found that the majority (63%) of very large employers that formally analyzed the impact of their wellness programs on medical plan costs have reported savings equal to or greater than the cost of the wellness plan. *See* Mercer, National Survey of Employer-Sponsored Health Plans: 2015 Survey Report, attached as Exhibit A, at 41.[7]

Third, group health plans have implemented wellness programs not only because they reduce costs and mitigate health risks, but also because the HRA and biometric screening components of these programs provide extremely valuable aggregate information used to identify health risks in the benefits plan population, forecast the cost of those risks, and ultimately to develop and design the terms of the health plan based on those risks. *See generally Seff*, 778 F. Supp. 2d at 1374; RAND Corporation, *supra*, at 37-38 (Employer C's health plan uses HRA and biometric data on cholesterol levels, blood pressure, blood glucose, and body mass index "to evaluate variations in risks and biometric measures over time."); Henke, Goetzel, McHugh & Isaac, *supra*, at 491 ("Johnson & Johnson routinely analyzes aggregate health assessment data to identify health risk trends among employees.").

In the instant case, for example, the employer's consultants used aggregate data to calculate projected insurance costs for the benefit year, to recommend what the employer should charge plan participants for maintenance medications and

[7] The survey defined a large employer as one with 5,000 or more employees.

preventative care, to make recommendations regarding plan premiums (including higher premiums for tobacco users), and to decide to purchase stop-loss insurance as a hedge against the possibility of unexpectedly large claims. District Court Op. at 12-13. A wellness program could, for example, show a population of participants at risk for diabetes, in which case the plan could reasonably anticipate higher future claims costs and adjust premiums to account for these costs. *See, e.g.*, American Diabetes Association, "The Cost of Diabetes" (June 22, 2015) ("People with diagnosed diabetes incur average medical expenditures of about $13,700 per year, of which about $7,900 is attributed to diabetes. People with diagnosed diabetes, on average, have medical expenditures approximately 2.3 times higher than what expenditures would be in the absence of diabetes.").[8] In sum, group health plans use this aggregate data "on a macroscopic level [to] form economically sound benefits plans for the future." *Seff*, 778 F. Supp. 2d at 1374.

C. EEOC's oversight is as unnecessary as it is unauthorized, because wellness program participants already are protected against discrimination under current law.

Under current law, wellness program participants under a health plan already are protected against invasion of privacy and unlawful discrimination.

First, where, as here, a wellness program is part of a group health program, federal privacy protections under the Health Insurance Portability and Accountability

[8] Available at http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html.

Act of 1996 ("HIPAA") apply. HIPAA's privacy protections are fully protective of participant interests and set forth significant detail regarding the uses and disclosures of personal health information ("PHI"). Under HIPAA, a group health plan generally may not disclose PHI to a person's employer without that person's authorization, subject to certain limited exceptions. The HIPAA privacy rule allows a plan sponsor to (i) receive PHI from the group health plan for enrollment and disenrollment purposes, (ii) to receive PHI from the group health plan for plan administration functions provided the plan sponsor certifies to the group health plan that its plan documents have been amended to restrict permitted uses and disclosures of PHI, and (iii) to receive summary health information (generally de-identified PHI) for obtaining premium bids and modifying, amending or terminating the group health plan. *See* 45 C.F.R. § 164.504(f). These standards amply protect plan participants regarding use of health information collected as part of a wellness program.

Second, the ADA insurance safe harbor itself has an appropriate built-in limitation to ensure that employers do not use the insurance safe harbor to discriminate against employees with disabilities. The insurance safe harbor makes clear that it "shall not be used as a subterfuge to evade the purposes of subchapter I and III." 42 U.S.C. § 12201(c). The legislative history explains the intended meaning of this provision: "[An employer may] not deny a qualified applicant a job because the employer's current insurance plan does not cover the person's disability or because of an anticipated increase in the costs of the insurance." H.R. REP. NO. 101-

485, pt. 3, at 71 (1990). As the district court properly held, a wellness program does not operate as a subterfuge unless the employer uses the information gathered from the medical examinations or screenings to engage in unlawful disability discrimination, in violation of the express statutory purpose behind the ADA. 42 U.S.C. § 12101(b)(1); District Court Op. at 14.

HIPAA and the subterfuge clause amply protect against any risk that an employer would use the insurance safe harbor provision to obtain and use disability-related information for a discriminatory purpose.

D. EEOC's attempt to exercise regulatory authority over wellness plans not only is unauthorized by the ADA but also is harmful to health plans.

Viewed through the lens of how employer health plans use wellness programs, it is clear that the district court's interpretation of the insurance safe harbor is correct and should be affirmed. EEOC has no authority to regulate wellness programs that are part of health plans under the insurance safe harbor.

1. Exempting wellness programs from the insurance safe harbor directly contradicts the language of the safe harbor.

EEOC asks the Court to ignore the plain language of the insurance safe harbor and hold that it does not apply to wellness programs that are part of employer-provided health plans. EEOC Opening Br. at 17-19. After EEOC filed its opening brief, it issued final regulations that similarly state that the safe harbor does not apply to wellness programs, even if such plans are part of an employer's health plan. *See*

EEOC Notice of Supplemental Authority (citing 29 C.F.R. § 1630.14(d)(6)).

EEOC's argument and its final regulation directly contradict the plain language of the insurance safe harbor. The safe harbor appears in Subchapter IV of the ADA and clearly provides an exception to "Subchapters I through III of this chapter," in their entirety. 42 U.S.C. § 12201(c). Section 12112(d)(4) is one of many provisions contained in Subchapter I and is clearly covered by this exception. *See* 42 U.S.C. § 12112(d). On its face, the insurance safe harbor plainly applies to wellness programs that are "terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks." 42 U.S.C. § 12201(c). There is no statutory or other basis for EEOC's attempt to exempt one specific provision of Subchapter I (Section 12112(d)(4)) from the insurance safe harbor when by its plain language the safe harbor applies equally to all provisions contained in Subchapters I through III. The law is clear that EEOC's attempt to create a new exception to the insurance safe harbor from whole cloth is not entitled to any deference. *Demarest v. Manspeaker*, 498 U.S. 184, 185 (1991) ("Administrative interpretation of a statute contrary to the statute's plain language is not entitled to deference."); *Pub. Employees Ret. Sys. of Ohio v. Betts*, 492 U.S. 158, 171 (1989) (rejecting EEOC regulation because "of course, no deference is due to agency interpretations at odds with the plain language of the statute itself."); *see also Sullivan v. Zebley*, 493 U.S. 521, 532 (1990) (agency interpretation entitled to no deference where it sought to limit applicability of statute more narrowly than the statutory language).

EEOC argues that employer wellness programs should be categorically excluded from the insurance safe harbor because the ADA contains a separate exception for "voluntary medical examinations . . . which are part of an employee health program." *See* EEOC Opening Br. at 18 (discussing 42 U.S.C. § 12112(d)(4)(B)). EEOC contends that the 1990 House Report on Section 12112(d)(4) acknowledged that employers were offering "voluntary wellness programs" and expressly approved of them so long as they were voluntary and the medical records are maintained confidentially. *See* EEOC Opening Br. at 21. However, EEOC's argument is logically flawed. Some wellness programs are an integral part of an employer's group health plan; others are separate, stand-alone programs that cover all of an employer's employees, regardless of health plan participation. The mere fact that Section 12112(d)(4) expressly permits voluntary wellness programs that are *not* part of employer health insurance plans in no way suggests that the insurance safe harbor does not apply to wellness programs that are part of employer health insurance plans. For the same reason, EEOC's argument that applying the insurance safe harbor to wellness programs renders the voluntary employee health program provision superfluous is meritless. Again, EEOC ignores the fact that many employer wellness programs are not at all tied to a group health plan and thus only would be subject to the voluntary employee health program exception.

Moreover, the purpose of Section 12112(d)(4) is not at all thwarted by

following the plain language of the ADA and permitting medical examinations and inquiries as part of employer health plan wellness programs. As the district court recognized, the core purpose of the ADA is expressly set forth in the statute, and it is "to provide a clear and comprehensive national mandate for the ***elimination of discrimination against individuals with disabilities***." 42 U.S.C. § 12101(b)(1); District Court Op. at 13-14.[9] The legislative history of Section 12112(d)(4) also makes clear that the same purpose – eliminating discrimination – applies to this particular provision. The House Judiciary Committee explained that ***Section 12112(d)(4) was intended to prohibit inquiries and medical examinations that "serve[] no legitimate purpose, but simply serve[] to stigmatize the person with a disability. . . ."*** H.R. REP. NO. 101-485, pt. 3, at 44 (1990). Section 12112(d)(4) was not intended to prohibit *all* employee medical examinations and inquiries, but rather only those without a legitimate, non-discriminatory purpose. Such prohibited

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[9] *See also* H.R. REP. NO. 101-485, pt. 2, at 22-23 (1990) ("The purpose of the ADA is to provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life; to provide enforceable standards addressing discrimination against individuals with disabilities, and to ensure that the Federal government plays a central role in enforcing these standards on behalf of individuals with disabilities.").

EEOC incorrectly asserts that "one of the core purposes of the ADA was to prohibit involuntary medical exams and disability-related inquiries." EEOC Opening Br. at 17. As recognized by the district court, EEOC is wrong. District Court Op. at 13-14. The mere existence of a provision in a law does not make it a "core purpose" of the law. Rather, as noted above, the core purpose of the ADA – to eliminate disability discrimination – is set forth in the statute itself.

examinations and inquiries included fitness tests that were commonly used for the sole, discriminatory purpose of excluding employees from promotions because of their disabilities. With respect to employee benefits plans, on the other hand, Congress expressly "***recognize[d] the need for employers, and their agents, to establish and observe the terms of employee benefits plans, so long as these plans are based on legitimate underwriting or classification of risks***." H.R. REP. NO. 101-485, pt. 3, at 70 (1990) (emphasis added). Importantly, allowing employers to engage in these important benefits plan activities creates no risk that the employer will engage in any unlawful disability-based discrimination. Employers need only aggregate, non-personalized information to engage in legitimate risk underwriting, classification and administration of their health plans. They neither need nor are they privy to any individualized disability-related information. Thus, there is no risk that wellness programs like the one in this case will result in any unlawful discriminatory employment actions that were intended to be prevented by the ADA.

Finally, there are ample privacy and other protections already in place under HIPAA and the insurance safe harbor to prevent any misuse of health information gathered by wellness programs. *See supra* at 11-13. HIPAA and the subterfuge clause adequately protect against any risk that an employer may use the insurance safe harbor provision to obtain and use disability-related information for a discriminatory purpose.

2. The insurance safe harbor covers employers.

EEOC next repeatedly asserts that even if the insurance safe harbor does apply to wellness programs, the safe harbor only applies to "underwriting" by "insurers." *See, e.g.*, EEOC Opening Br. at 6, 8, 10, 16, 18, 19, 23, 27-38. But the statutory language is much broader. It covers not only "insurers," but also any "entity that administers benefit plans" and any "person or organization" that establishes, sponsors, observes, or administers the terms of a bona fide benefit plan. 42 U.S.C. § 12201(c)(1)-(2). The ADA's legislative history, much of which is *cited by EEOC*, makes clear that the safe harbor applies to employers with benefits plans. *See* EEOC Opening Br. at 19-21. The House Committee on Education and Labor, for example, explained that "section 501(c) [the insurance safe harbor] is intended to afford to insurers ***and employers*** the same opportunities they would enjoy in the absence of this legislation to design and administer insurance products and benefit plans . . . ." H.R. REP. NO. 101-485, pt. 2, at 137-38 (1990). In addition, the House Committee on the Judiciary expressly recognized "***the need for employers, and their agents, to establish and observe the terms of employee benefits plans, so long as these plans are based on legitimate underwriting or classification of risks***." H.R. REP. NO. 101-485, pt. 3, at 70 (1990). The plain language and legislative history of the insurance safe harbor provision directly refute EEOC's argument that the insurance safe harbor is limited to "insurers" or otherwise does not apply to employers with benefits plans.

3. *The insurance safe harbor broadly covers benefit plan terms that are based on underwriting risks, classifying risks, and administering risks.*

The language of the insurance safe harbor and its legislative history make clear that the safe harbor broadly encompasses terms of benefits plans that are "based on underwriting risks, ***classifying risks, or administering such risks.***" 42 U.S.C. § 12201(c)(1)-(2). As noted above, the House Committee on Education and Labor intended the insurance safe harbor to permit "employers the same opportunities they would enjoy in the absence of [the ADA] to ***design and administer*** insurance products and benefit plans in a manner that is consistent with basic principles of insurance risk classification. . . . The provisions recognize that ***benefit plans (whether insured or not) need to be able to continue business practices in the way they underwrite, classify, and administer risks, so long as they carry out those functions in accordance with accepted principles of insurance risk classification***." H.R. REP. NO. 101-485, pt. 2, at 138 (1990).

Accepted principles of insurance risk classification include decisions based on not only actuarial principles, but also "actual or reasonably anticipated experience." H.R. REP. NO. 101-485, pt. 3, at 71 (1990); *see also, e.g., Doukas v. Metropolitan Life Ins. Co.*, 950 F. Supp. 422, 428 (D.N.H. 1996) ("As these sections make clear, the ADA would not require that an insurance company base its insurance decisions on actuarial principles; instead, the ADA also permits such decisions to be related to actual or reasonably anticipated experience."); *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1208

(N.D. Ga. 1997) ("The principle to be drawn from these cases appears to be that insurance practices are protected to the extent they are in accord with sound actuarial principles, reasonably anticipated experience, or bona fide risk classification. This principle is consistent with the legislative history of the ADA.").

Further, as shown above, many health plans use wellness program data to classify and administer risks by offering targeted wellness services to at-risk plan participants that are designed to and often successfully do mitigate their health risks. *See supra* at 8-10. Health plans also use wellness program information to "reasonably anticipate" future claims experience and costs. *See supra* at 10-11. If, for example, the wellness program data reveals an increase or decrease in the population of employees with certain health risks, the plan can reasonably anticipate higher or lower future claims costs and premiums can be adjusted to account for these anticipated costs. *Id.* The district court and the court in *Seff* correctly concluded that these uses clearly are based on "underwriting risks, classifying risks, and administering risks." District Court Op. at 11-13; *Seff*, 778 F. Supp. at 1374, *aff'd* 691 F.3d 1221 (11th Cir. 2012).

Contrary to the plain language of the insurance safe harbor and its legislative history, EEOC seeks to narrowly circumscribe the insurance safe harbor to cover only the underwriting process by which a plan is initially obtained and priced (*see* EEOC Opening Br. at 18, 29, 36). Underwriting, however, is an ongoing process that spans the life of the plan. On an annual and even sometimes more frequent basis, employers must make decisions about plan design and pricing, including deductible

amounts, copay amounts, and coverage provisions. Where, as here, an employer or its consultants use data derived from a wellness program in making these decisions, it clearly is engaging in underwriting risks, classifying risks, and administering risks and is covered by the insurance safe harbor provision. *See Seff*, 778 F. Supp. 2d at 1374 (employer used data to "decide what type of benefits plans will be needed in the future in light of these risks," which constitutes "underwriting and classifying risks on a macroscopic level so it may form economically sound benefits plans for the future"). And as shown above, the insurance safe harbor applies to more than just underwriting on its face; it encompasses a wide variety of activities related not only to underwriting, but also to classifying and administering risks. EEOC's suggestion that the insurance safe harbor should be limited to "underwriting" lacks any basis in the statutory language or legislative history of the ADA.

4. EEOC's position would prevent health plans from maximizing participation in wellness programs.

Moreover, EEOC's arguments, if accepted, would have serious practical consequences to the detriment of health plans (and by necessary implication the employees who benefit from them). Crucially, if the insurance safe harbor is held *not* to apply to wellness programs that are part of health plans, health plans could only offer wellness programs on a "voluntary" basis. EEOC's definition of "voluntary" has changed over time, with EEOC once claiming that any penalty makes a wellness

program involuntary,[10] and EEOC now claiming that certain limited incentives or penalties are permitted. *See* 29 C.F.R. § 1630.14(d). It is beyond dispute that requiring participation in a wellness program or incentivizing non-participants maximizes wellness program participation. *See, e.g.,* RAND Corporation, *supra*, at 59 (employer reported participation rate increase from 20% for non-incentivized screenings to 98.9% participation where $50 weekly penalty was imposed for non-participation). Requiring or at least maximizing employee participation in health plan wellness programs is critical to their success in identifying and mitigating health risks and in using aggregate data to forecast future costs and design benefit plans.

Conclusion

Wellness programs are a critical part of many employer health plans, and EEOC has no authority to regulate these wellness programs under the plain language of the ADA insurance safe harbor. EEOC's tortured contrary reading of the ADA lacks any factual basis considering the ways in which Flambeau and other employer health plans use wellness programs, and it lacks any basis in the statutory language or the legislative history of the ADA. For all of these reasons, the Court should affirm summary judgment in Flambeau's favor.

[10] *See EEOC v. Honeywell Int'l. Inc.*, No. 14-4517, Doc. 4, Memorandum in Support of EEOC's Application for Temporary Restraining Order at 2 ("[A]n examination is not voluntary when the employer imposes a penalty on the employee if he or she declines to participate.").

Dated: June 2, 2016

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Industry Committee

CERTIFICATE OF WORD COUNT

Pursuant to FRAP 32(a)(7)(C), the undersigned certifies that this brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,657 words.

Pursuant to Fed. R. App. P. 32(a)(5), the undersigned certifies that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point font, Garamond typeface, as permitted by Seventh Circuit Rule 32(b).

Dated: June 2, 2016

s/ Michael S. Burkhardt
Michael S. Burkhardt

CERTIFICATE OF SERVICE

I, Michael S. Burkhardt, hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system on June 2, 2016.

I certify that all participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

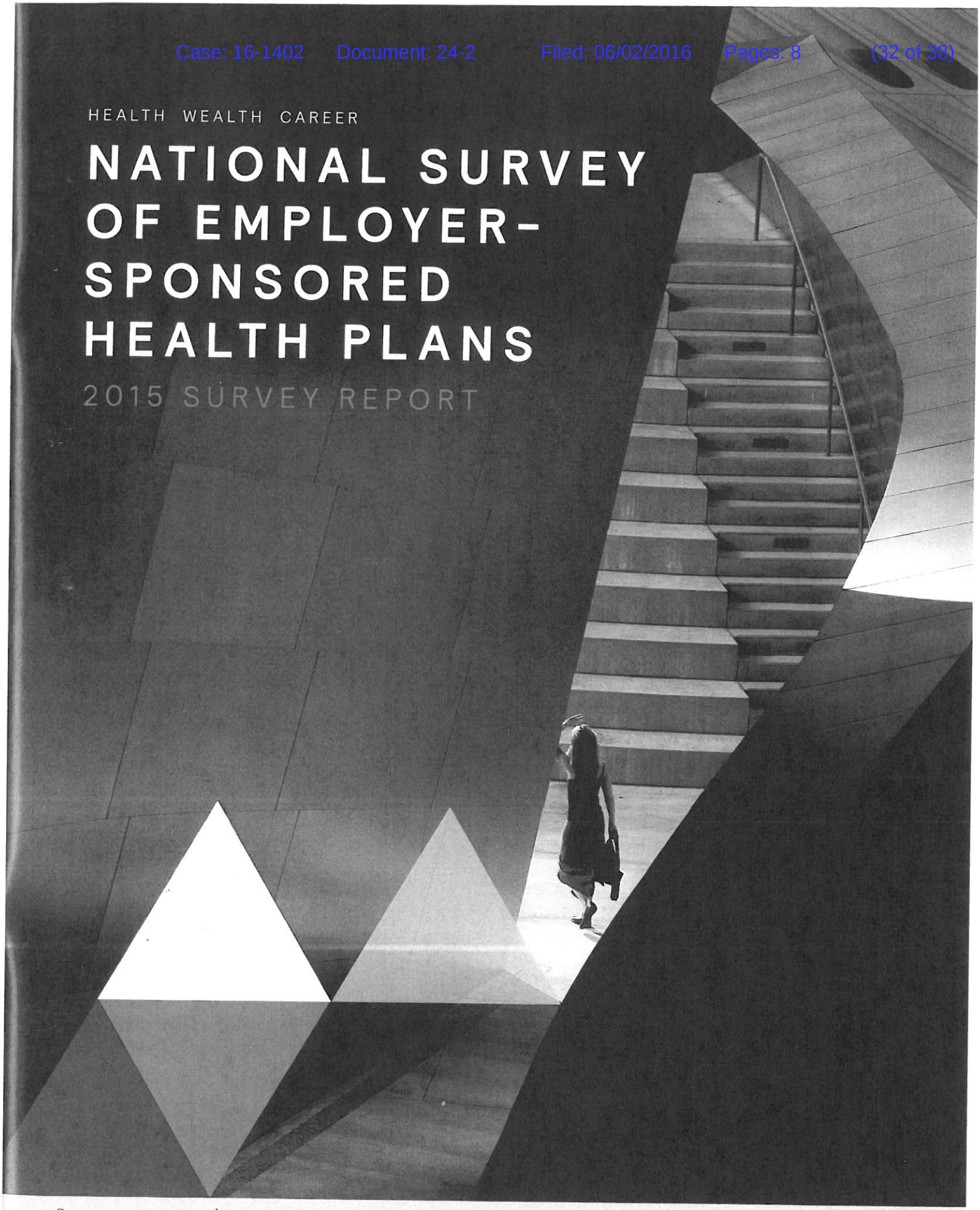
s/ Michael S. Burkhardt
Michael S. Burkhardt

EXHIBIT A

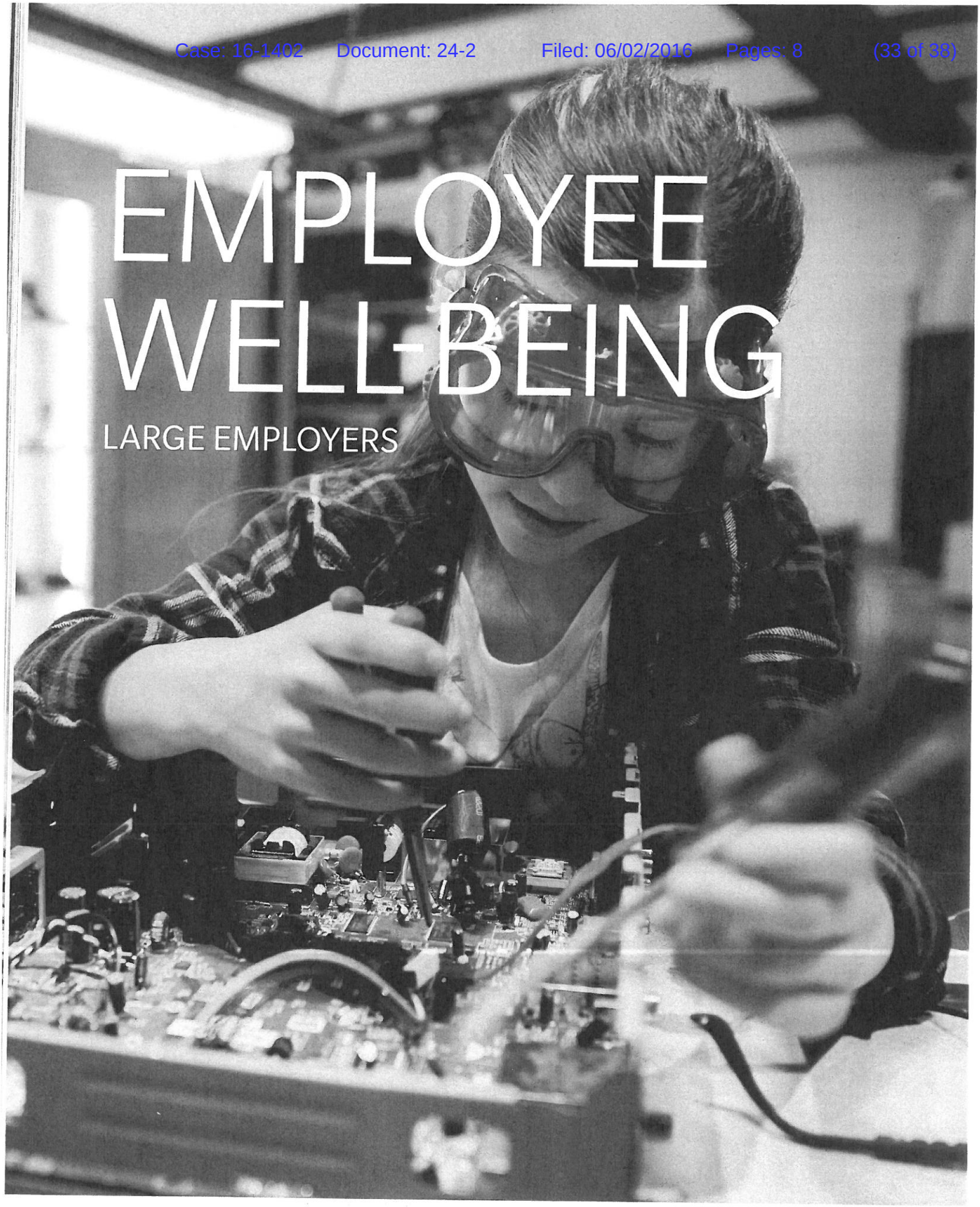
HEALTH WEALTH CAREER

NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

2015 SURVEY REPORT



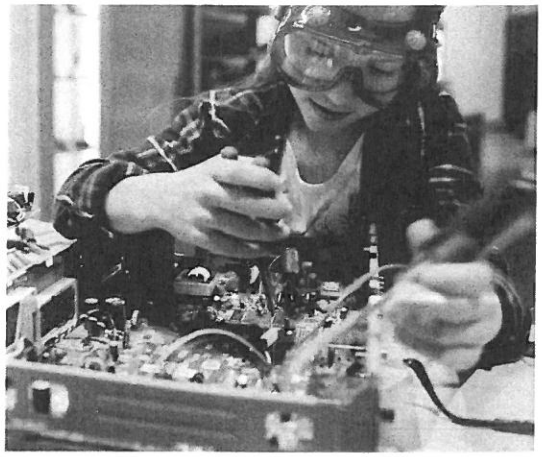
MAKE TOMORROW, TODAY MERCER



EMPLOYEE WELL-BEING

LARGE EMPLOYERS

As the view that employee well-being encompasses emotional health and financial security as well as physical health becomes more broadly accepted, we're seeing traditional workforce wellness programs expand to include resources to help employees achieve goals in each of these areas — for example, resiliency training and support for budgeting, debt reduction and retirement planning. Employers are tapping the power of technology and social networks to help employees stay focused on health goals outside the workplace, especially those managing chronic conditions. While financial incentives continue to make an important difference in boosting participation in key gateway activities like health assessments and biometric screenings, new thinking on how to build intrinsic motivation to improve well-being is shifting attention to including families and creating a workplace environment that makes the healthy choice the easy choice. Continued growth in health advocacy programs underscores that navigating the health care system can itself be a source of stress (Fig. 51). Offering support at the time it's needed most can help ensure employees and their families get the right care and avoid unnecessary expense.



Nearly all large employers offer programs designed to support health and well-being, and each year more are purchasing optional services from health plans (34 percent, up from 27 percent in 2014) or contracting with outside vendors (48 percent, up from 43 percent) to provide specialty services (Fig. 52).

Health assessments, lifestyle coaching and disease management have become the mainstays of employee health and well-being programs. Programs that diagnose and treat sleep disorders are offered by 39 percent of large employers, up from 32 percent in 2014. Resiliency or stress management programs, designed to help employees understand the difference between useful stress and harmful stress and give them techniques to better handle stress, are offered by 42 percent.

FIGURE 51

Offer health management programs

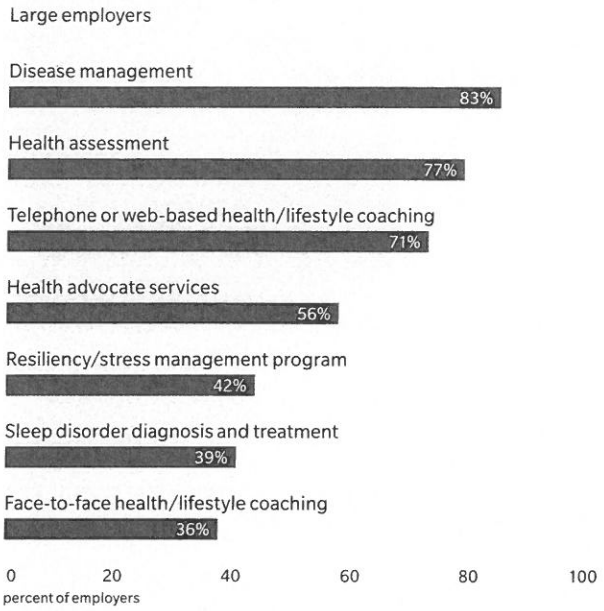
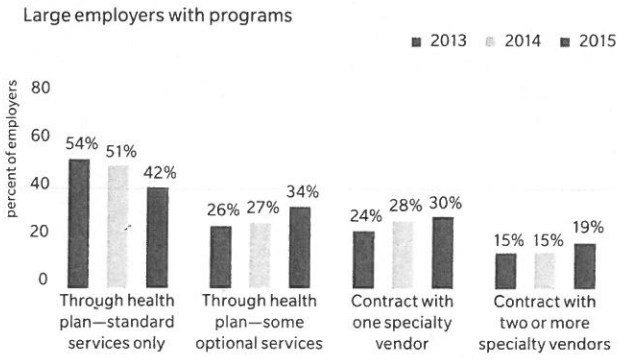


FIGURE 52

How health and well-being programs are offered



Worksite biometric screenings are offered by well over half of employers (Fig. 53), making it easier for employees to take this important first step in uncovering health risks (and to earn a reward, when one is offered). Employers are also providing a range of less formal activities at the workplace to engage employees and create a culture of health: yoga, exercise classes or weight loss programs; group challenges, where work units or locations compete in health-related competitions; personal challenges; and peer-to-peer support opportunities (such as weight loss support groups, peer coaching and affinity groups for sports activities). On-site fitness facilities are provided by 42 percent of employers at some or all locations, while others subsidize fitness facility memberships or provide discounts.

Financial security is a component of well-being for most people, and as employees take on more responsibility for health care spending, the tie-in to health becomes even stronger. While the most common type of financial support provided is currently around retirement planning (59 percent), more than a fourth of large employers offer tools or resources to assist with budgeting or debt management (27 percent), and a similar number offer a financial calculator to assist with managing personal/family expenses (26 percent).

Beyond programs, organizational policies can help create a culture of health. Over two-thirds of employers have a tobacco-free workplace policy. More than half support healthy eating choices by providing healthy options in the cafeteria or at company events, and some (21 percent) have a policy regarding responsible alcohol use. Nearly half explicitly encourage physical activity with features or resources in the work environment such as a gym, standing desks or walking trails — although only 15 percent allow employees to take work time for physical activity or stress management. Job-share options, flex time or other policies that support work-life balance are in place for 34 percent of employers.

Technology is playing an important role in the evolution of health and well-being programs, allowing employers to offer programs or apps that are novel, intuitive, transparent and personalized. Today 60 percent of employers use some form of technology-based resource to encourage employees

to become more engaged in caring for their health. These include gamification programs and wearables or apps to monitor activity. A few employers even provide devices to transmit health measures (such as blood sugar levels) to providers, which can help employees who are managing a chronic condition be more proactive.

About half of employers (49 percent) offered financial incentives in connection with their health and well-being programs. While incentives are most commonly used to encourage employees to participate in programs, 21 percent of employers provide outcomes-based incentives for achieving, maintaining, or showing progress toward specific health status targets (this is down from 23 percent in 2014). Employers are more likely to use financial rewards (43 percent) than financial penalties (13 percent). Eighteen percent of employers provide nonfinancial rewards such as recognition or token gifts, and a few make charitable donations on behalf of employees (4 percent). Nearly three-fourths (73 percent) of employers that offer incentives require employees to complete multiple actions to earn the incentives.

FIGURE 53

Engaging employees to improve health habits

Activities and technology-based resources offered

	Large employers
Activities	
Worksite biometric screening	56%
On-site exercise, yoga, or weight loss programs	43
Business unit/location group challenges	45
Personal challenges	40
Peer-to-peer support	19
Technology-based resources	
Mobile apps	30
Wearables/apps to monitor activity	24
Onsite kiosks	7
Devices to transmit health measures to providers	4
Other web-based resources/tools	40

Employers are increasingly recognizing that including spouses and even children in programs can help build not only participation but better engagement. Nearly two-thirds of employers (62 percent) make spouses eligible for key elements of their programs, and 28 percent make children eligible. Only half of the programs that include spouses also make them eligible for incentives, which may be one reason that eligible spouses are less likely to complete health assessments than are eligible employees. The average health assessment completion rate is 29 percent for eligible spouses, compared to 44 percent for employees.

FIGURE 54

Program incentives

Large employers

Provide incentive for completing health assessment	54%
Median premium reduction	$360
Median cash/gift card amount	$50
Provide incentive for completing validated biometric screening	40%
Median premium reduction	$415
Median cash/gift card amount	$50
Provide incentive for participating in lifestyle coaching program	27%
Median premium reduction	$360
Median cash/gift card amount	$100

Health assessments and biometric screening

The majority of large employers offer a health assessment, typically a questionnaire used to identify individuals with health risks and steer them to programs to help them manage or prevent chronic illness. More than half of those offering a health assessment (54 percent) provide an incentive for completing it (Fig. 54). The most common type of incentive offered is a lower premium contribution, followed by cash or a gift card. The median premium differential is $360 and the median cash incentive is $50 (in both cases, more than one action may be required to earn the reward). Incentives can strongly influence participation. Among employers that offer an incentive, 48 percent of eligible employees complete an assessment, compared to 26 percent among employers not offering an incentive (Fig. 55).

FIGURE 55

Average participation rates for well-being programs

Large employers

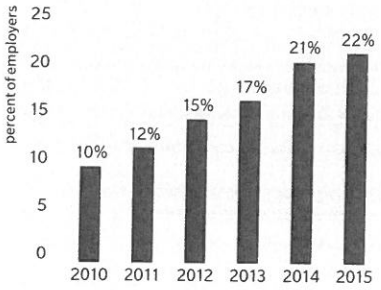
	Offer incentives	Don't offer incentives
Health assessment	48%	26%
Biometric screening (validated)	52	22
Lifestyle management program*	20	12

*Percent of identified persons actively engaged in the program.

FIGURE 56

Offer lower premium contributions to non-tobacco users

Large employers



Biometric screenings typically check body mass index (BMI), blood pressure, lipid profiles and glucose levels. While these tests can be administered at a doctor's office or laboratory, over half of all large employers (and nearly three-fourths of those with 10,000 or more employees) conduct on-site biometric screening events. Regardless of whether on-site screenings are offered, 40 percent of employers offer incentives for obtaining a validated biometric screening. On average, 52 percent of eligible employees are screened when incentives are offered, compared to 22 percent when they are not. The most common form of incentive for biometric screenings is a lower premium contribution, offered by 51 percent of employers providing incentives, with a median differential of $415. When cash is offered as the incentive, the median amount is only $50 (down from $100 in 2014).

Lifestyle coaching

Lifestyle coaching is most commonly delivered by phone or the Web, but 36 percent of employers offer face-to-face coaching. In many cases, the conversation is directed by the results of a health assessment and biometric screening. Only about a fourth of employers that offer a lifestyle management program provide an incentive for participation, most often cash or gift cards, with a median value of $100. When the incentive is a lower premium contribution, the median premium differential is $360.

When incentives are offered in connection with a coaching program, on average 20 percent of employees identified as meeting the risk criteria become actively engaged in the program, meaning they have completed at least one coaching call beyond an initial enrollment (or "welcome") call, or have validated completion of an online lifestyle management module. Just 12 percent become actively engaged when no incentives are offered.

Tobacco-use and other outcomes-based incentives

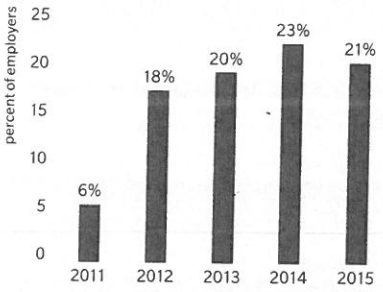
While incentives are still most commonly used to encourage greater participation, some employers are willing to reward performance, especially the largest employers. While 22 percent of all large employers offer lower premiums for non-tobacco users, 44 percent of those with 20,000 or more employees do (Fig. 56). The median annual reduction in premium per employee is $500. Most employers with special provisions relating to tobacco employ the honor system to determine an employee's tobacco-use status; only 16 percent test some or all employees claiming to be non-tobacco users (for example, with cotinine testing). E-cigarettes are increasingly being included in the definition of tobacco; 59 percent of employers that have policies or incentives regarding tobacco use include them, up from 46 percent in 2014.

The survey also asked employers about rewarding participants for achieving or showing progress towards specific health targets such as BMI or waist circumference, blood pressure and cholesterol. As with participation incentives, there was no growth in the use of these outcomes-based incentives; 21 percent of employers offer them, down slightly from 23 percent in 2014 (Fig. 57). The median maximum amount awarded is $500.

FIGURE 57

Provide incentive for achieving or maintaining health status targets

Large employers



Return on investment

While improving employee health and well-being intuitively seems like a win-win for employees and the organizations they work for, many employers have been challenged to demonstrate a tangible return on their investment (ROI). Very large employers (those with 5,000 or more employees), which have the resources to conduct a formal analysis of the impact on medical plan cost, have been reporting positive ROI in terms of medical plan savings for years. About two-fifths of employers of this size have attempted to formally measure the impact of their programs on medical cost, and of those the majority (63 percent) report savings equal to or greater than the cost of the health and well-being programs. But we're seeing a shift in program evaluation from ROI to VOI — from return on investment to value of investment. The focus on value acknowledges the important role of well-being in attraction and retention (becoming the employer of choice), and in productivity and performance. While employers are just beginning to use these types of metrics, we're seeing some promising early results — 20 percent of those with 5,000 or more employees have measured improvement in attraction and retention, and 16 percent have measured improvement in productivity.

Many factors contribute to a successful health and well-being program, including leadership support, strong data-driven solutions, and innovative technology tools and resources. Employers that incorporate the largest number of best practices in their programs have been shown to have better results. The HERO Health and Well-Being Best Practices Scorecard in Collaboration with Mercer is a free online assessment tool that has been used by more than 1,700 employers. Employers use their program score (which is automatically calculated upon submission of the completed Scorecard) to assess their programs relative to their peers and to identify opportunities for improvement. At the same time, the information employers provide is aggregated to build a database that is used by industry experts to learn more about what makes employee health and well-being programs work. For more information, please visit www.mercer.com/HERO.