5-17-2013

Using Incentives in Workplace Wellness Programs: The Impact of Federal Employment Discrimination Laws

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May 2013

PART I: INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (ACA), signed into law on March 23, 2010, brought sweeping reforms to the United States health care delivery system. Among its many changes, the legislation provides an unprecedented emphasis on preventive care and wellness initiatives. One of these initiatives permits employers to offer worksite wellness programs to their employees and dependents, using incentives of up to 30 percent – and in some cases as high as 50 percent – of the cost of their health insurance benefits to induce participants to reach certain health outcomes or biometric standards. With a projected annual cost of $6,500 for single coverage when the law becomes effective in 2014, these incentives may be valued from $1,950 to $3,250.

Such significant incentives have raised concern among some and gained praise from others. There is concern that "linking premiums and cost-sharing to health status will make the cost of insurance much higher for the very people who need health care most. … Research has shown that people with conditions like cancer, diabetes and heart disease are much less able to treat and manage their condition when their insurance costs are high."[1] In contrast, business groups and industry leaders tout workplace wellness programs (WWPs) as one of the most effective ways to combat the rising cost of health insurance: "Employers of all sizes have embraced wellness-based incentives to help control costs, and companies are now looking at ways to design and optimize their programs to maximize their positive impact on health for both the organization and employees."[2]

Before looking more closely at the legal implications of implementing a WWP that uses incentives to the full extent permitted under the ACA, it may be instructive to present the history of the legislation that permits these significant incentives. Known as the "Safeway Amendment," the wellness incentive provisions of the ACA were added under a Senate amendment based in large part on published statements of Steven Burd, CEO of Safeway, Inc. In an opinion piece in the June 12, 2009 Wall Street Journal, Mr. Burd claimed:

> "The key to achieving these savings is health-care plans that reward healthy behavior. As a self-insured employer, Safeway designed just such a plan in 2005 and has made continuous improvements each year. The results have been remarkable. During this four-year period, we have kept our per capita health-care costs flat (that includes both the employee and the employer portion), while most American companies' costs have increased 38% over the same four years."[3]

This "success story" was picked up by President Obama and Senators of both parties in support of the amendment to the ACA permitting the increased incentives. Sadly, more careful investigation revealed that the claims just weren't true. Instead, the savings noted by Mr. Burd were realized as a result of a 2006 overhaul of the Safeway employee health plan that shifted more costs to employees, thus bringing down company costs. But the wellness program that Mr. Burd referenced was not implemented until 2009:

> [A] review of Safeway documents and interviews with company officials show that the company did not keep health-care costs flat for four years. Those costs did drop in 2006 -- by 12.5 percent. That was when the company overhauled its benefits, according to Safeway Senior Vice President Ken Shachmut.
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> The decline did not have anything to do with tying employees' premiums to test results. That element of Safeway's benefits plan was not implemented until 2009, Shachmut said.
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> After the 2006 drop, costs resumed their climb, he said.
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> Even as Burd claimed last year to have held costs flat, Safeway was forecasting that per capita expenses for its employees would rise by 8.5 percent in 2009. According to a survey of 1,700 health plans by the benefits consultant Hewitt Associates, the average increase nationally was 6.1 percent.[4]

It is ironic - but perhaps fitting as well - that the inspiration for this legislation arose out of a disputed interpretation of the cost impact of a worksite wellness program: as discussed in detail below, the data concerning the cost-savings to be gained under these programs is mixed, at best, and the legality of an employer's WWP may well depend in part on being able to justify that the incentives offered to employees under these programs bear some reasonable relationship to those savings. These requirements are not imposed by the ACA itself – indeed, the ACA specifically denies

that such a cost justification is necessary – but arise out of the myriad of other federal employment laws impacting ESHI plans.

Part II of this paper analyzes those laws and attempts to bring some order to the conflicting requirements. (Although, as one legal scholar has noted, "Undertaking to place all the[se] laws into some harmonious and analytically coherent framework is likely a futile effort.")[5] Part III summarizes the health research that may support or restrict various WWP designs in light of these requirements. Part IV synthesizes Parts II and III in an attempt to offer a practical approach to WWPs in order to comply with the applicable federal employment laws.

Before turning to the legal analysis in Part II, there are two terms used extensively in this paper that require definition. The first is "incentives." As used in this paper, an incentive is a monetary or other inducement of financial value designed to encourage changes in behavior that result in a desired health outcome. The inducement can be negative or positive – a penalty or reward. Neither the ACA provisions nor the precursor statute distinguish between the two in defining the requirements for incentives, so the term is used accordingly in this paper to apply equally to negative and positive inducements. Where a distinction between negative and positive is necessary for clarity, the terms "penalty" and "reward" will be used.

The second phrase used frequently herein is "benefit levels." This phrase is used to describe the overall effect of incentives applied to a WWP or employer-sponsored health insurance (ESHI) plan. Incentives may be used alone or in combination to reduce or increase an employee's levels of required premium payments, deductibles, copayments and coinsurance (the percentage of covered costs paid by the plan). All of these will impact the value of an employee's coverage and overall healthcare costs, and I use the phrase "benefit levels" to refer to the cumulative effect of incentives.

Finally, many employers offer their WWP incentives to dependents of employees as well. For simplicity, the discussion below is restricted to employee coverage only, but the same concepts and restrictions will apply equally to dependent coverage.

PART II: LEGAL ANALYSIS

Overview. This Part II analyzes the application of six distinct federal employment discrimination statutes that bear on the design and implementation of WWPs. It is important to note at the outset that each of these laws has as its main purpose the protection of employees from workplace discrimination in one form or another. This protection extends to an employer's compensation and fringe benefit practices, and the application of incentives offered through a WWP will result in differential compensation and/or benefit levels for employees who qualify for the incentive. The resulting disparity in benefit levels may be considered discriminatory and will be permitted – if at all – only as an exception to each statute's prohibition on employment discrimination. The fact that one of these statutes may permit a particular feature of a WWP does not exonerate it if the same feature does not meet the requirements for an exception from another statute. Thus, every feature of a WWP must meet all of the statutory requirements.

The analysis is further complicated by the fact that each statute protects a different group of employees. Protection from discrimination is afforded under the various laws on the basis of race, national origin, religion, sex, age, disability, health status and information about an individual's genetic health risks. The protected classification is typically referred to as the "protected group," and any given employee may fall into multiple protected groups.

To bring some sense to all of this, each statute is analyzed below with a view to (1) identifying the protected group; (2) describing the nature of the prohibited discrimination; and (3) defining the extent to which exceptions under the statute permit disparate benefit levels.

Before addressing these laws individually, it should be noted that there are other federal and state laws that will govern the design and implementation of a WWP but which are outside the scope of this paper. These include, among others, the federal Internal Revenue Code, which imposes unfavorable tax treatment on employers and highly compensated employees if the WWP and associated ESHI impermissibly discriminate against less highly compensated employees. The tax code, however, does not provide affirmative protection to individuals or groups of employees. That is, employees cannot sue to enforce these provisions, and employers can choose to discriminate in favor of highly compensated employees if they are willing to accept the tax consequences.

Finally, it should also be noted that each of these federal statutes includes provisions designed to protect the confidentiality of the medical information received in connection with wellness programs. It is outside the scope of this paper to discuss each of these provisions separately, but the collective impact of all such provisions results in a blanket prohibition on sharing individually identifiable information with the employer. This information can only be provided to the employer in aggregate form.

Federal Employment Nondiscrimination Laws. This analysis of the applicable statutes begins with a review of the Health Insurance Portability and Protection Act (HIPAA), which serves as the precursor to the ACA provisions regarding WWP incentives. Changes made to the HIPAA rules by the ACA are discussed next. Following that analysis, each of the other four statutes is addressed in turn.

HEALTH INSURANCE PORTABILITY AND PROTECTION ACT (HIPAA)

SUMMARY OF KEY NONDISCRIMINATION PROVISIONS: HIPAA prohibits an employer from discriminating against employees in its ESHI plan eligibility or cost sharing provisions on the basis of a "health factor," which includes factors such as pre-existing conditions, physical or mental health status, and medical history. An exception to this general prohibition permits the employer to offer incentives of up to 20 percent of the cost of ESHI coverage to induce employees to participate in a bona fide wellness program that is reasonably designed to

The Health Insurance Portability and Accountability Act of 1996[6] (HIPAA) prohibits employer-sponsored health insurance (ESHI) from discriminating against employees (and their covered dependents) on the basis of health factors.[7] A limited exception to this prohibition allows a health plan to distinguish on the basis of health status to the extent the plan is part of a "bona fide wellness program" designed to promote health or prevent disease.[8] The wellness program provisions in the ACA are essentially a statutory codification of the regulatory standards developed by the U.S. Departments of Labor, Health and Human Services and Treasury (collectively, the "Departments") in their joint capacity as the regulatory agencies responsible for interpreting HIPAA.

Under their collective regulatory authority, the Departments issued final regulations in 2006[9] that established the guidelines for such bona fide wellness programs under HIPAA. These regulations distinguished between (1) participatory wellness programs, which either (a) offered program incentives on the basis of participation alone (and not on achievement of a particular health factor) or (b) did not offer incentives at all; and (2) outcomes-based programs that provide an incentive for meeting one or more health standards.

Participatory programs. The HIPAA regulations established only minimal requirements for participatory programs. Compliance with the statute's non-discrimination requirements were deemed met if the program was made available to all similarly situated individuals on the basis of "bona fide employment classifications based on the employer's usual business practices," and not on the basis of health factors.[10] These rules would permit an employer,

for example, to subsidize gym memberships or offer smoking cessation programs for specified groups of employees on the basis of work location, classification as management vs. hourly workers, or similar distinctions. It would not be permissible to limit availability of the benefit on the basis of BMI, smoking status or other health factors. The regulations contained no requirements based on program content, reasonableness or evidence that the program was designed to promote health or prevent disease.

Programs based on meeting health standards. For programs that condition receipt of an incentive on meeting one or more health standards, the HIPAA regulations require the following conditions:

1. Size of Incentive. The total incentive for all such wellness programs offered by the employer may not exceed 20 percent of the total cost of coverage under the plan.
2. Reasonable Design. The program must be reasonably designed to promote health or prevent disease. This standard requires the program to have a "reasonable chance" of improving health or preventing disease, it must not be overly burdensome, it must not be a subterfuge for discrimination on the basis of health status, and it must not be "highly suspect" in method.
3. Frequency of Opportunity to Qualify. The program must give eligible individuals an opportunity to qualify for the incentive at least once per year.
4. Uniform Availability with Reasonable Alternative Standards. The incentive must be available to all similarly situated individuals. In addition, a reasonable alternative standard must be available to individuals for whom, during the period for which the incentive is available, it is unreasonably difficult due to a medical condition to satisfy, or for whom it would be medically inadvisable to attempt to satisfy, the applicable health factor standard. For example, if an incentive is available for employees with a normal BMI, those who exceed

this standard may be able to qualify for the same incentive if they exercise for 30 minutes, 5 times per week.[11]

Like the standards for participatory programs, there are no substantive requirements for program content. Indeed, the preamble to the final regulations makes it quite clear that there is no requirement for programs to meet evidence-based guidelines:

> The "reasonably designed" requirement is intended to be an easy standard to satisfy. To make this clear, the final regulations have added language providing that if a program has a reasonable chance of improving the health of participants and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor and is not highly suspect in the method chosen to promote health or prevent disease, it satisfies this standard. *There does not need to be a scientific record that the method promotes wellness to satisfy this standard.* (Emphasis added.)[12]

These standards are the precursors to the ACA provisions that now govern WWPs.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

KEY NONDISCRIMINATION PROVISIONS: The ACA extends the HIPAA prohibition against discrimination on the basis of health factors to additional insurance markets. It also codifies the HIPAA standards for WWPs described above and increases the permissible level of incentives to up to 30 percent of the cost of ESHI coverage, with an alternate level of up to 50 percent of the cost of ESHI coverage in the case of programs designed to induce employees to cease or reduce

The ACA statutory language changed very little of the standards established under the HIPAA regulations. It did, however, enlarge the permissible incentive to a maximum of 30 percent of the cost of coverage under the ESHI plan. In addition, the statute authorizes the Departments to permit by regulation an increase in this limit to 50 percent of the cost of coverage. Regulations interpreting the ACA provisions were proposed in November 2012 (Proposed Regulations).[13]

The proposed regulations issued by the Departments closely follow the standards established under HIPAA. They implement the increased incentive of 30 percent as permitted by the statute and provide some clarification of the prior standards but - with one exception – make no

significant changes to the HIPAA regulations. Drawing on their statutory authority to increase the level of incentives up to a maximum of 50 percent of the cost of coverage, the Proposed Regulations would permit an incentive of 50 percent for standards-based programs that target the reduction or prevention of tobacco use.

Participatory Programs. The Proposed Regulations make it clear that participatory programs which do not require participants to meet a health-based standard are not subject to the limits and requirements imposed on standards-based programs. As under HIPAA, these programs must continue to be made available to all similarly situated employees.

Programs based on meeting health standards. The Proposed Regulations modify the HIPAA standards for these programs as follows:

1. Size of Incentive. As noted above, the total permissible incentive for standard-based wellness programs has been increased to 30 percent. Programs targeting tobacco use may provide an incentive of up to 50 percent of the total cost of an individual's coverage. Note that these limits are cumulative: the incentive structure of all of an employer's wellness programs, taken together, may not total more than 30 percent (or 50 percent if the programs include a tobacco use element.)
2. Reasonable Design. The Proposed Regulations reiterate the standard established under HIPAA. That is, the program must have a "reasonable chance" of improving health or preventing disease, it must not be overly burdensome, it must not be a subterfuge for discrimination on the basis of health status, and it must not be "highly suspect" in method. Although the Proposed Regulations do not go so far as to require that a program be evidence-based, they do invite comments on whether evidence- or practice-based standards should be required.

3. Frequency of Opportunity to Qualify. This standard was not changed: the program must give eligible individuals an opportunity to qualify for the incentive at least once per year.
4. Uniform Availability with Reasonable Alternative Standards. While the Proposed Regulations do not change this requirement, the preamble provides some clarification of the rules. As noted previously, an incentive must be available to all similarly situated individuals. This includes the requirement that a reasonable alternative standard must be available to individuals for whom medical conditions make it unreasonably difficult or inadvisable to attempt to satisfy the health standard on which the incentive is based. The Proposed Regulations provide some guidance on these "reasonable alternatives":
    - A wellness program may require medical certification that a reasonable alternative is necessary due to an individual's medical condition.
    - If a wellness plan requires a participant to complete a health educational program, the plan must provide the required program and must pay any program fees.
    - If a wellness plan requires a participant to complete a diet program, the plan must pay program fees but is not required to pay for the cost of the food.
    - If the wellness plan requires compliance with the recommendations of a health care provider engaged by the plan or the employer, the plan must accommodate the recommendations of the individual's physician if he or she states that the plan-provided recommendations are not medically appropriate for that individual. It is not clear whether the plan must pay for any medical supplies and services furnished in accordance with the health care provider's recommendations. If those supplies and services are a covered benefit under the wellness plan or the employer's ESHI, they can be provided in accordance with plan terms (which may require the individual to pay some part of the cost), but it is not clear whether it would be considered reasonable for

a wellness plan to require an individual to follow (and pay for) recommended supplies and services that are not covered by either the wellness or ESHI plan.

In summary, the Proposed Regulations under ACA closely follow the standards established under HIPAA. The only substantive change from prior law is the increase in the permissible incentives to 30, and in some cases, 50 percent of the cost of ESHI. These limits apply only to programs that condition receipt of the incentive on achievement of a defined health outcome; programs based only on participation are not subject to any such limits. However, as discussed in the following sections, four other federal laws may put additional limits on the use of incentives in wellness programs.

TITLE VII OF THE CIVIL RIGHTS ACT OF 1964 (TITLE VII)

KEY NONDISCRIMINATION PROVISIONS: Title VII prohibits *disparate treatment* in benefit levels on the basis of race, sex or ethnic origin (that is, benefit levels that are specifically based on race, sex or national origin). There is no exception for cost-justified disparities. Title VII also prohibits *disparate impact* (that is, benefit levels that are not specifically based on race, sex or national origin, but which have disparate impact on members of the protected group). Application of this rule in the context of WWP incentives is not clear. If prohibited discrimination is found in a case

The Civil Rights Act of 1964 protects against discrimination on the basis of sex, race, religion and national origin: Title VII of that Act prohibits discrimination against these protected classes in the employment context, which includes the "compensation, terms, conditions or privileges of employment."[14] Benefits under the employer's ESHI plan are a fringe benefit of employment, and as such are subject to the Title VII protections.

Title VII has been interpreted by the courts to prohibit not just different treatment explicitly or intentionally based on one of the protected classifications, but also on the grounds of disparate impact.[15] If a member of a protected class can show that a facially neutral policy falls more harshly

on the protected group, the policy will be considered in violation of the law. However, the application of this rule in the context of disparate benefit levels under ESHI is highly nuanced.

It is common for ESHI plans to exclude particular conditions from coverage. Common examples include exclusions for cosmetic surgery, treatments for obesity and contraceptive treatments. Where these exclusions relate to pregnancy, the exclusions are unlawful under Title VII. Other exclusions related to reproductive health - an area closely linked to sex-based distinctions – are not so clearly prohibited.

The history of the prohibition on pregnancy-based exclusions highlights the reluctance the courts have shown to extend protection to disparate benefits on the basis of sex. In an early case, the Supreme Court ruled that an exclusion of benefits for pregnancy was not discriminatory on the basis of sex.[16] This decision was rapidly overruled by Congressional action which amended Title VII to include the Pregnancy Discrimination Act (PDA). The PDA explicitly establishes that benefit distinctions based on pregnancy are considered to be a violation of Title VII's prohibition on gender-based discrimination since only women can get pregnant.[17]

However, challenges brought against benefit exclusions for reproductive health conditions other than pregnancy have not been as successful. Courts have ruled that benefit exclusions related to reproductive processes such as contraception and infertility are not necessarily discriminatory, as these functions affect men as well. Under general Title VII concepts, a showing by plaintiffs of the disparate impact of these exclusions on women should be sufficient to establish a prima facie case, but to date such cases have generally been dismissed for failure to state a cause of action.[18] In contrast, an employee who was fired for missing work to undergo infertility treatments was found to have a cause of action under Title VII. The court reasoned that, although infertility affects both men and women, only women will need to take time off from work to receive the treatments; thus the employer's action was discriminatory.[19] So, while a disparate impact claim

based on disparate benefit levels should theoretically be available upon an adequate showing of evidence, the courts have shown reluctance in granting relief on this basis.[20]

Outside of the ESHI context, it is well established that Title VII prohibits employers from establishing job qualification criteria that have a disparate impact on a protected group. Unless the employer can show that those criteria are "job-related for the position in question and consistent with business necessity,"[21] qualification criteria with a disparate impact will be invalidated. Thus physical fitness and weight criteria that fall disproportionately on a protected group –typically along gender lines- are not permitted when they serve to limit or eliminate candidates for job hiring or promotion.

As noted in more detail in Part III, many of the biometric standards established under WWPs show disparities among racial, ethnic and gender lines. Given the reluctance of courts to find a Title VII violation in the context of ESHI plans, it is difficult to predict whether the use of such biometric standards as qualification criteria for incentives would violate Title VII if they impact a protected group in a disproportionate manner.

Unlike the Americans with Disabilities Act and Age Discrimination in Employment Act, discussed below, if a Title VII violation is found, an employer generally may not defend its actions on the basis of cost justification. At least in the case of a facially discriminatory benefit structure (that is, disparate treatment), this is an absolute prohibition: an employer may not justify a discriminatory health benefits structure on the grounds that the distinctions are necessary due to the increased cost of providing benefits for a particular racial, ethnic or sex-based condition. [22] There is some indication that the courts would be willing to acknowledge a cost justification defense in the case of a benefit structure with discriminate impact, however.[23]

Given the uncertainty of the application of Title VII in the context of ESHI in general and WWPs in particular, employers are urged to use caution in developing WWP standards that may have a disparate impact on protected groups.

AMERICANS WITH DISABILITIES ACT (ADA)

KEY NONDISCRIMINATION PROVISIONS: The ADA prohibits employers from discriminating on the basis of disability. Benefit levels may not discriminate against individuals on the basis of disability unless the benefit plan is (1) not a subterfuge to evade the purposes of the ADA and/or (2) the disability-based distinction is justifiable on the basis of underwriting risks and classifications.

The Americans with Disabilities Act of 1990, as amended by the Americans with Disabilities Amendment Act of 2008 (the ADAAA)(collectively, the ADA)[24] protects an employee from discrimination by the employer on the basis of the employee's own disability or the disability of his or her family members. For purposes of applying the law, a disability is defined as an impairment that substantially limits one or more life activities. A person with the impairment is protected under the statute if, with a reasonable accommodation of the limiting effects of the impairment, he or she can perform the essential functions of the job.

During the nearly 20-year history of the ADA prior to the ADAAA, the issue of what constituted an "impairment" covered by the statute was heavily litigated. In response to perceived overly restrictive definitions of the term by the courts, the ADAAA was enacted to make it easier for individuals to establish the existence of a disability.[25] Under the new definitions of "impairment" and the "life activities" that must be impaired in order to show a disability, virtually all chronic diseases may be considered disabilities. Diabetes and obesity were rarely found to be disabilities under the ADA prior to its amendment by the ADAAA, but some of the first court decisions issued after the effective date of the ADAAA have ruled both diabetes and obesity can be disabilities within

the meaning of the ADA.[26] This broadened definition will impact the degree to which the ADA will affect worksite wellness programs and ESHI.

In particular, two provisions of the ADA relate to worksite wellness programs and ESHI. The first is a provision designed to preempt employer discrimination by limiting the extent of the employer's access to the employee's medical information. The second prohibits employers from discriminating against disabled employees (and/or their disabled dependents) under the terms of their ESHI plans.

Medical Examinations. The first of these provisions generally prohibits the employer from requiring any sort of medical examination of employees unless the examination is job-related and consistent with business necessity.[27] However, the employer may "conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."[28] The Equal Employment Opportunity Commission (EEOC), which has enforcement and regulatory authority under the ADA, has indicated that wellness program inquiries about medical histories and biometric screenings to determine whether a health standard has been reached are medical examinations within the meaning of this provision, and thus must be voluntary.

Many worksite wellness programs feature health risk assessments (HRAs), and many employers encourage their employees to complete the assessment on an annual basis. Employers commonly provide financial and other incentives as an inducement to do so. The EEOC has objected to this practice in some cases, arguing that the examination is not "voluntary," as required by the statute, if the incentive is too valuable. In opinion letters issued by EEOC Office of Legal Counsel to employers requesting guidance, the agency has indicated that it would be a violation of the ADA to make (1) eligibility to participate under the employer's ESHI,[29] or (2) receipt of cash reimbursement for medical expenses (in an undisclosed amount) from a health reimbursement

account,[30] contingent upon completion of a health risk assessment. It appears that the EEOC took the position at one point that an incentive of up to 20 percent of the cost of coverage under the ESHI – that is, the permissible incentive then permitted under HIPAA – would not violate the ADA. However, the EEOC later withdrew the opinion letter that established this position and replaced it with a letter that was silent on this issue, citing as the reason for its removal the fact that the agency had not specifically been asked to establish the upper limits on incentives.[31] In its most recent guidance – in the form of a non-binding, informal discussion letter issued by the EEOC Office of Legal Counsel – the agency stated that a wellness program that includes "disability-related inquiries (such as questions about current health status asked as part of a health risk assessment) or medical examinations (such as blood pressure and cholesterol screening to determine whether an employee has achieved certain health outcomes)" are not "voluntary" if the employer requires participation or "penalizes employees who do not participate."[32]

The EEOC has indicated that it is considering the extent to which an employer may offer incentives to participate in wellness programs. Until further guidance is issued, it appears that it may not be permitted under the ADA to offer incentives in the form of (1) incentives of such value that to decline participation in a wellness program could not be considered "voluntary," or (2) penalties (possibly at any level) for refusing to participate. It should be noted that this limitation would apply to all employees – not just those deemed to be disabled under the ADA.

Discriminatory ESHI Plans. The second provision of the ADA that impacts the legality of employer-sponsored wellness programs is one that generally prohibits employers from discriminating on the basis of disability with respect to "employee compensation, ... and other terms, conditions, and privileges of employment."[33] ESHI is considered to be a fringe benefit and, under this statutory language, it would be impermissible for an ESHI plan to discriminate on the basis of disability.[34] This provision clearly limits an employer's ability to exclude a disabled worker

from health insurance coverage or charge him more for the coverage just because the employee is "disabled." The analysis becomes more complex when one considers the extent to which a plan can deny benefits or charge higher rates based on a particular medical condition. It is not so clear whether a WWP that reduces an employee's health insurance premiums by 30 percent for achieving certain health standards – such as a "normal" BMI or blood pressure reading – would be prohibited.

On the one hand, such a standard would appear to be discriminatory when applied to an employee who is deemed to be disabled *because of* obesity or hypertension. However, an exception to the general prohibition on discriminatory fringe benefit plans provides that "the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law" are not considered to violate the terms of the ADA, provided that the plan is "not used as a subterfuge to evade the purposes of [the ADA]."[35] The use of increased premiums to address higher-cost health risks is the classic definition of an "underwriting risk," so the WWP use of higher premiums as an incentive to reach a healthier standard may in fact come within the exception to the general rule. Under the recently enacted ACA, however, it is no longer permissible to take health status (other than age and smoking) into account for purposes of underwriting risks.

The EEOC has never issued regulations defining the extent of this ADA exception, although it published informal guidance in 1993 that outlined a test for determining whether or not plan exclusions would violate the ADA.[36] The first step in the test requires a determination that the benefit exclusion is a "disability-based distinction." By way of example, the EEOC contrasted a hypothetical plan that excludes coverage for blood transfusions with one that excludes treatment for hemophilia. The latter would be an impermissible disability-based distinction while the former would not – even though the effect of the exclusion would be more detrimental to someone with

hemophilia. If the exclusion is a disability-based distinction, then the plan will be found to have violated the ADA if the exclusion results in "disability-based disparate treatment that is not justified by the risks or costs associated with the disability."[37]

The new, broader definition of disability under the ADA may make it difficult to apply this guidance. Since the ADAAA defines a disability to include nearly any chronic disease – even if the disease is fully controlled by medical or other intervention - the difficulty in establishing the limits of plan liability without making "disability-based" distinctions is enormous. Notably, the EEOC has indicated that this guidance is under review because of these significant changes made by the ADAAA.

It is important to note that the EEOC requirement to provide a cost-justification for disability-based plan exclusions has received little support in court. In decisions rendered prior to the ADAAA, the courts gave short shrift to the EEOC's interpretation and focused instead on whether purportedly discriminatory provisions were a "subterfuge" to evade the purposes of the ADA. Based on a prior decision of the Supreme Court interpreting the same "subterfuge" language in the Age Discrimination in Employment Act (discussed in more detail below) to mean a deliberate attempt to avoid the prohibited discrimination, the courts have rejected claims of disability discrimination if the employer can show that the contested plan exclusion pre-dates passage of the ADA.[38] It is not clear how the subsequent passage of the ADAAA and ACA may impact future court decisions. While the ACA provisions do not supersede the ADA, an employer could plausibly argue that any program intended to comply with the ACA Proposed Regulations (which require that wellness programs be "not overly burdensome [and] not a subterfuge for discriminating based on a health factor")[39] could not be a subterfuge to avoid the ADA.

In the only case to date to address the application of the ADA to wellness programs in particular, the court addressed the permissibility of employer-provided incentives for employees to

complete a health risk assessment. In that case, the employer's wellness program provided that an employee's biweekly paychecks would be reduced by 20 dollars if the employee did not complete an HRA required under the wellness program. An employee brought suit claiming that this violated the ADA prohibition on involuntary medical examinations. The court rejected this argument and found that the practice was permissible as a bona fide health plan and that the surcharge was legitimately based on "underwriting risks, classifying risks or administering such risks."[40] The court did not engage in the required EEOC analysis that the penalty be justified by the risks or costs associated with it. It was enough that collecting information about the health of covered employees was necessary for

> underwriting and classifying risks on a macroscopic level so [the employer] may form economically sound benefits plans for the future. Furthermore, the wellness program is an initiative designed to mitigate risks. It is based on the theory that encouraging employees to get involved in their own healthcare leads to a more healthy population that costs less to insure. In other words, the program is based on underwriting, classifying and administering risks because its ultimate goal is to sponsor insurance plans that maintain or lower its participant's premiums.[41]

The employee benefit community has applauded this decision because it sidesteps the EEOC's apparent disapproval of incentive-based HRAs as involuntary medical examinations. However, this may be a pyrrhic victory. While this court approved the use of incentives as being in accordance with the ADA's "bona fide" plan exception, it was based on satisfaction of the requirement that the incentive met the "underwriting risks" criteria. However, the incentive at issue was a penalty of 20 dollars per biweekly paycheck, or $520 dollars per year. While this court did not demand a showing that the use of the health risk assessment would in fact lower the ESHI premiums, an employer that plans to impose the full 30 or 50 percent penalty permitted under the ACA may find it far more difficult to prove that the penalty is justified on the basis of "underwriting risks" when compared to anticipated program results.

AGE DISCRIMINATION IN EMPLOYMENT ACT (ADEA)

KEY NONDISCRIMINATION PROVISIONS: The ADEA prohibits employment discrimination against employees over the age of 40. Benefit levels that impose disparate benefits on employees in this age group are permitted if the employer can show that the benefit disparities are cost-justified.

The Age Discrimination in Employment Act of 1967, as amended (ADEA), protects workers older than the age of 40 from employment discrimination on the basis of age. Like Title VII and the ADA, this includes a prohibition on discrimination in compensation and fringe benefits such as ESHI. And, like the ADA, there was an exception in the ADEA for bona fide employee benefit plans that are not a "subterfuge" to evade the purposes of the Act. In fact, the ADA exception for bona fide benefit plans and the qualification to the exception for plans that are a subterfuge was patterned after the ADEA language. The Proposed Regulations under the ACA use the same language. This is significant, because the subterfuge provision of the ADEA has a life of its own.

As originally enacted, the ADEA had the bona fide benefit plan and subterfuge provisions noted above. The EEOC interpreted that language to require that a plan that provided lower benefits or charged more for the same benefits on the basis of age was a subterfuge unless the employer could show that the reduction in benefits was justified on the basis of age-related cost increases. Thus, the employer was required to either provide equal benefits or incur equal costs for those benefits to older employees.[42]

This interpretation was resoundingly rejected by the United States Supreme Court in *Public Employees Retirement System of Ohio v. Betts.*[43] The Court abruptly dismissed the EEOC's regulations and ruled that the statutory prohibition on benefit plans that were a "subterfuge to evade the purposes of the Act" meant exactly what it said, using the common meaning of the word subterfuge: a "scheme, plan, stratagem, or artifice of evasion." That is, unless the employer specifically intended to provide a plan that evaded the intentions of the ADEA, the plan was not a subterfuge. Since the plan at issue in *Betts* had been adopted prior to passage of the ADEA, the Court reasoned, it could not be a subterfuge to evade the purposes of the Act.

Congress reacted swiftly and enacted the Older Workers Benefit Protection Act in 1990 to reverse the Supreme Court's interpretation. The reference to subterfuge was removed from the ADEA and replaced by a statutory provision that codified the equal cost/equal benefit rule developed by the EEOC in its regulations. This provision was intended "to make clear that . . . the *only* justification for age discrimination in an employee benefit is the increased cost in providing the particular benefit to older individuals."[44]

It is not at all clear how this provision will be applied in the context of wellness programs. Age is inextricably linked with health and it is, in part, the aging of the workforce that has accelerated the increase in costs of ESHI. A wellness program that requires satisfaction of a single biometric standard may be challenged on the grounds that the standard is discriminatory on the basis of age if it is unreasonably difficult for older employees to meet the standard. And in many cases, even if an older employee meets the standard, the plan is still likely to incur more costs on behalf of that older employee. May the employer adjust its incentive scheme on this basis, if it can show it is cost-justified? These are issues that have not yet been addressed in the courts.

It is also important to note that even though the language of the ADA and the ACA are derived from the "subterfuge" language that originated in the ADEA, only the ADEA has been amended to remove that language. Courts still rely on the Supreme Court's interpretation of the subterfuge language in the *Betts* case (that is, there must be a deliberate intention to evade the statutory purposes) in ADA cases.[45] It remains to be seen how courts will treat the same language in the ACA provisions regarding wellness programs.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

KEY NONDISCRIMINATION PROVISIONS: An employer may not discriminate against individuals on the basis of information regarding their genetic health risks, and benefit levels may not vary on the basis of an individual's genetic information or family medical history. There is no exception for cost-justified disparities.

The Genetic Information Nondiscrimination Act of 2008 ("GINA")[46] protects employees from employment discrimination on the basis of their genetic information. Unlike the ADA, which was enacted in the face of historic job discrimination on the basis of physical or mental disability, GINA was passed in light of the recent advances in genetic testing to head off the potential for discrimination in employment and health insurance coverage on the basis of an employer's concern about an employee's potential *future* bad health based on his genetic characteristics.[47] The Act therefore generally prohibits employers and health plans from "request[ing] or requir[ing]"[48] an individual to provide "genetic information" unless one of the statutory exceptions applies.

GINA defines genetic information to include the medical history and results of genetic testing of an individual *as well as his family members.* Under this definition, a family medical history, which is commonly requested as part of a health risk assessment, is protected under GINA. The regulations do permit a wellness program or health plan to request this information as part of a health risk assessment, but only if there is no reward or inducement offered and no penalty applied in connection with an employee's decision to provide the genetic information or family medical history.[49] In addition, the HRA cannot be completed prior to or in connection with enrollment in the employer's ESHI plan.[50]

Since employers frequently provide incentives to induce employees to complete HRAs, the GINA regulations impose a rather awkward bifurcation on the assessment process. The wellness program must either provide a separate assessment without associated incentives or penalties, or it must present questions about family medical history in a separate section with a notice that

informs employees that no incentive will be withheld or penalty applied if the employee fails to complete that section. (The same rules would apply if the health risk assessment requested information about other genetic information such as the results of genetic testing.)[51]

Note that these rules apply only to permit a wellness program to request family medical history and other genetic information in connection with an assessment process. The information gained from the assessment cannot be used under any circumstances to impose higher health plan costs. It can be used to develop wellness interventions and favorable health plan benefits for preventive care and disease management programs for the individual, but flexibility in plan design is restricted by regulations issued by the two agencies with enforcement authority under GINA, the EEOC and the Department of Labor.

Under regulations promulgated by the EEOC, a plan that offers financial incentives or enhanced benefits applicable to individuals whose genetic information reveals a higher risk of developing a particular disease or condition must also offer the incentives or enhanced benefits to individuals who have manifested the condition. If, for example, a disease management program offers enhanced benefits or financial incentives to participate in a diabetes prevention program, the EEOC regulations require that the incentives and/or enhanced benefits must be offered to all individuals who have been diagnosed as having diabetes, as being at risk for diabetes due to lifestyle choices, or as being at risk based on genetic information.[52]

Additional restrictions arise under Department of Labor regulations, which provide that enhanced benefits or financial incentives for participation in such a program may be provided to individuals identified as being at risk on the basis of genetic information only if those individuals initiate a request to participate in the intervention.[53]

Summary Of Part II. Taken together, these nondiscrimination laws prohibit discriminatory benefit levels established on the basis of race, ethnic origin, sex, age, disability, health status and

genetic health risks. In the case of disability and age, disparate benefit levels may be permitted if the employer can show some cost justification for the disparities. Since the health outcome goals established under a WWP and the incentives provided to induce achievement of those goals will bear directly on the benefit levels available to employees, they must be designed in a way that avoids violation of any of these prohibited types of discrimination. In addition to these nondiscrimination provisions, there are limitations on the employer's ability to require medical examinations and/or collect health information, including genetic information. These provisions also will impact the design of the WWP. Part III looks at common features of WWPs in light of these requirements.

PART III: WORKSITE WELLNESS PROGRAM FEATURES

Overview. In order to avoid violation of the federal employment nondiscrimination statutes, WWPs must ensure that their outcome-based requirements to earn incentives do not intentionally or in practice discriminate on the basis of race, sex, ethnic origin, age, disability, health status and/or genetic information. The first section in this Part III evaluates common biometrics and other WWP features to identify potentially discriminatory practices.

Since the statutes permit disparate benefit levels under some circumstances if the employer can show cost justification, the incentives will need to be proportional to the expected effectiveness of the incentives to impact health behaviors and the resulting cost savings to the employer. The next two sections in this Part III report on the literature regarding (1) the likelihood that incentives will be effective in encouraging employees to adopt healthy behavior and lifestyle changes, and (2) the potential effect such changes will have on employer ESHI plan costs.

Potential for Disparate Impact. This section examines some common features of outcome-based WWPs and evaluates the potential for creating prohibited discrimination under the

laws discussed above. These features include certain common biometric readings and requirements for certain amounts or levels of physical activity.

Biometric readings. Many outcome-based WWPs condition receipt of an incentive on obtaining one or more "normal" scores for blood pressure (120/80mmHg), BMI ($\leq$ 25 kg/m^2) and/or cholesterol (<200 mg/dL). However, these markers are subject to significant variation among racial, gender and age groups, all of which are protected groups under the laws discussed in Part II. This creates some risk that imposing the same standards on all groups will result in disparate impact on one or more of the protected groups.

BMI, for example, is an inexpensive, non-invasive method of determining a person's variance from a normal weight. The extent to which such variance impacts the person's health, however, is frequently more a matter of adiposity than the mere weight-to-height ratio measured by BMI, and the relationship between BMI and adiposity varies significantly on the basis of age and sex: it underestimates adiposity in the elderly and overestimates it in men.[54]

Blood pressure and cholesterol levels tend to show racial and gender differences as well, with women more likely than men to score higher cholesterol levels,[55] and non-Hispanic blacks more likely to exhibit high blood pressure than whites or Mexican Americans.[56] Furthermore, as with the potential for a BMI measurement to over-simplify its impact on health risks, studies have shown that using blood pressure measurements at a single standard (140/90mmHg) to diagnose hypertension has resulted in "widespread diagnostic inaccuracies."[57]

It also appears that the significance of the two elements of a blood pressure reading (systolic and diastolic readings) varies with age. For individuals at or under 50 years of age, diastolic readings over 80 were found to be an important predictor of mortality, but not in older adults. Conversely, for those over the age of 50, systolic readings at or over 140 had a significant impact on mortality.[58]

It is apparent that these population-based disparities in the absolute values exhibited for these biometrics as well as the disparities in the potential health consequences they reflect may result in a disparate impact on protected groups. However, the common value used for a particular biometric is, on its face, neutral as to each of these groups. To avoid a disparate impact claim under Title VII, the employer should be prepared to show that application of the biometric standards does not result in unfavorable treatment among protected groups. If there is concern that disparate impact may develop, it will probably be necessary to take a flexible, individualized approach to developing standards, as the use of standards explicitly based on sex or race may be considered facially discriminatory.

It is not clear how a challenge under the ADEA might fare. Although the biometric standards are facially neutral with respect to age, each one becomes increasingly difficult to meet with advancing age. This is precisely the reason the ADEA permits employers to provide disparate benefit levels on the basis of age. If an employer has already established age-based disparate benefit levels (such as charging older employees higher premiums for its ESHI plan) using the justification that it is more expensive to insure older workers, then using an aggressive incentive structure to further increase benefit level disparities among its older workers might be considered "double dipping" and therefore impermissible under the ADEA.

It is also possible that establishing a required BMI level, blood pressure metric, or blood glucose level may encounter challenges under the ADA. Although there have been no such challenges to date, these measures may be considered proxies for obesity, hypertension and diabetes, respectively, each of which can be a disability under the recent amendments to the ADA. If one of these measurements were recognized as a proxy for a disability, the employer would need to be able to show that incentives for reaching the measurement were based on underwriting risks or, if the EEOC were to challenge the practice, cost-justified.

In addition, the biometric measurements themselves are likely to be considered "medical examinations" under the ADA and therefore, under the views of the EEOC, subject to its restrictions on voluntary medical examinations: rewards must not be of such significant value as to make participation "involuntary" and penalties are not permitted. As noted in Part II, the only court to consider the meaning of a "voluntary medical examination" sidestepped this issue by looking instead at the permitted use of incentives as part of an underwriting risk under a bona fide health plan. As a result, an employer who uses an aggressive incentive program may run the risk of a challenge by the EEOC. Since the EEOC has not issued formal regulations (which have the force of law) and has published only its informal position (which does not), it is quite possible that the employer would win if it were to challenge the complaint in court. The cost of such an undertaking may be prohibitively expensive, however.

Exercise Program Requirements. It is common for WWPs to provide an incentive for employees to participate in a program of physical activity, such as walking five times a week for 30 minutes. If eligibility for incentives is not tied to performance goals (such as speed, strength, intensity or fitness biometrics), this program feature may be viewed as merely a participatory program. For ACA purposes, it would not be subject to limits on the use of incentives. If performance goals are established, it is possible that Title VII and/or ADEA liability might arise if the qualification criteria have an impermissible discriminatory impact, most likely on the basis of sex or age.

The ADA will also impose restrictions on a WWP exercise program feature, whether or not fitness goals are established. An alternative program must be developed for an employee who is physically disabled from participating in the required activity (or the requirement must be waived and the incentive paid without meeting the standard). Note that the ACA might require a similar

accommodation if the employee can show that it is "medically unreasonable" for the disabled employee to meet the required standard.

The impact of other types of disabilities is less clear. Consider the case of an employee who is affected by a visual disorder or neuromuscular complications that make walking possible, but unsafe to do so outside in uncontrolled conditions. Under these circumstances, the ADA would probably require the employer to either accommodate the employee's need for access to a gym or other facility that would permit the employee to walk safely. A case could be made that the ACA standards would also require that the employer provide a "reasonable alternative" even if the walking itself is not "medically unreasonable," but application of this requirement has not been addressed by the courts.

This hypothetical situation should be contrasted with a lower income employee who lives in an unsafe neighborhood and is fearful of walking outdoors. An accommodation for these unsafe conditions, while clearly a potential threat to health, is unlikely to be considered to be required under either the ADA or the ACA.

Effectiveness of Incentives. Disparate benefit levels, if permitted at all under the federal nondiscrimination laws, require an employer to justify the disparity on the basis of costs. In order to show that incentives are cost-justified, there should be some reasonable relationship between the magnitude of the incentive and the magnitude of its effect on behavior. However, as discussed below, there is no conclusive evidence that incentives are effective, and in any event it does not appear that there is a linear relationship between the size of the incentive and the expected change in behavior. The discussion below reviews the literature concerning the effectiveness of incentives.

Health Risk Assessments. Employers frequently use a health risk assessment as a gateway to further participation in a WWP. Depending on the results of the assessment, an employee may be invited to participate in one or more interventions designed to improve his health risks, such as

physical exercise, nutrition counseling or smoking cessation programs. In WWPs that include a disease management feature, an employee who is identified through an HRA as being at risk for cardiovascular disease or diabetes, for example, may become eligible for favorable preventive benefits under the employer's ESHI plan.

The HRA is considered under many programs to be an essential first step and employers frequently provide financial and other incentives to employees to complete the HRA. Recent research indicates that these incentives – at least when coupled with strong program communication and organizational support – do have a positive correlation with the response rate of employees asked to complete an HRA. This author notes, however, that the studies described below were funded by large commercial providers of employer-based health promotion programs.

In a cross-sectional study of 559,988 employees of 36 employers, the researchers found that employee response rates were positively associated with financial incentives.[59] The study found that the value of the incentive and the strength of program communication significantly increased employee participation. The study also found that response rates rose steadily with increasing incentive value from no incentive up to 100 dollars, but that there were diminishing returns for values greater than 100 dollars.

Taitel, *et al.* found similar results in a cross-sectional study of 882,275 employees of 124 different employers. The study found that the size of the incentive and the degree of organizational commitment and communication were significant predictors of employee response rates.[60] While both factors had a positive impact on employees' responses, the factors were themselves inversely related: to achieve a stated response rate, an employer with strong communications and organizational commitment needed to provide an incentive valued at 40 dollars, whereas an employer with low communication and organizational commitment needed to provide an incentive valued at 120 dollars.

Smoking Cessation Programs. A recent Cochrane Database systematic review[61] found that providing incentives for employees to quit smoking did not result in higher quit rates after six months. The authors acknowledged that there was some evidence that participation rates in a cessation program may be improved by rewarding participation, and increased participation could lead to higher absolute numbers of employees who quit smoking. However, the rewards did not improve results among those employees who chose to participate. The lack of differential between programs with incentives and those without was uniform across all 18 studies reviewed, with only one exception. This randomized controlled trial is discussed immediately below.

Volpp *et al*.[62] conducted a randomized control trial of 878 employees under a program that offered stepped incentives. These included $100 for completion of a smoking cessation program, $250 for cessation of smoking within 6 months after enrollment in the program, and $400 for remaining abstinent for an additional 6 months. Compliance was determined using biochemical tests. They found that the group receiving the incentive had significantly higher quit rates at all testing points. While not part of the study, the researchers noted that the relapse rate between the last test point and a 15- or 18-month assessment appeared to be considerably higher among the incentive group than rates in other published studies.

Weight Loss. Financial incentives used in weight loss programs appear to be even less effective. A systematic review of randomized controlled trials for treatment of overweight and obesity found no significant effect on weight loss or maintenance at 12 and 18 months.[63] A randomized control trial conducted after the systematic review found that financial incentives induced significantly greater weight loss in the incentive group than controls at the conclusion of the program, but these differences were no longer significant during the maintenance phase (during which incentives were discontinued).[64] One study has found that the use of financial incentives in diet and activity intervention actually undermined chances for success following

closure of the program: "across conditions, a main effect of financial motivation predicted a steeper rate of weight regained during the maintenance period." [65]

Summary. The evidence regarding the effectiveness of incentives is mixed at best, and does not seem to support use of incentives of the magnitude permitted under the ACA. This would not be problematic if incentives were required to be provided as rewards to employees that result in additional cost to the employer. Presumably an employer would not offer the maximum permissible incentive in the form of a cash reward if there was no evidence that the incentive would provide a return (in the form of reduced health costs) in excess of the cost of the incentive. There is some concern, however, that an employer could structure the incentive in the form of a penalty that would require the employee to pay significantly higher healthcare costs without concern on the employer's part about the cost-effectiveness of the incentive in terms of reduced health costs for the employer.

Cost Savings. To the extent an employer must justify an incentive program on the basis of cost, it may need to prove that the incentive program is effective to change behaviors and that those behaviors can be expected to result in reduced healthcare costs. There can be little argument that a significant portion of any ESHI plan's costs are attributable to the types of lifestyle and behaviors typically targeted by WWPs, such as smoking, overweight and lack of physical activity. Studies have certainly shown that employees who smoke and/or are overweight tend to have higher medical costs.

A recent retroactive cohort study[66] of medical claims costs during a 7-year review period showed that average annual medical care costs for smokers exceeded those of non-smokers by $1274. Average annual claims costs for overweight and obese individuals exceeded those of normal weight by an amount ranging from $382 for the overweight (BMI >25 and $\leq$ 30 kg/m^2) to $5467 for the morbidly obese (BMI > 40 kg/m^2). However, the study did not control for changes in smoking

status or BMI, so these significant cost increases are not necessarily representative of the cost savings a health plan could expect if its WWP was successful in inducing smokers to quit and obese employees to reach a normal weight.

A few studies have examined the impact of these types of changes on medical costs. In a large (n=10,601) 5-year retrospective study, Carls *et al*. found that employees who gained enough weight during the study period to move into the obese category (BMI $\geq$ 30) kg/m^2) experienced increased annual claims costs of $982 compared to those who remained below that threshold, but there was no significant difference in medical costs between those who remained in the obese category and those who lost enough weight during the study period to fall below the obese category.[67] For this study at least, it appears that keeping employees from gaining weight is more cost effective than inducing them to lose weight. A smaller study (n=279) similarly found no evidence of lower medical expenditures among individuals who lost at least five percent of their body weight.[68]

In a surprising outcome, the Carls study also found that employees who ceased using tobacco during the study period experienced significantly higher medical costs than those who did not. The authors suggest that this counter-intuitive result may reflect the propensity of tobacco users to quit following a diagnosis of serious illness.

There have been scores of published studies examining the overall medical claims cost savings realized by employers that sponsor comprehensive WWPs. Limitations of these studies are many: a lack of randomized control trials and biased results based on observational study design;[69] selection bias on the part of employees (the healthiest employees may be more likely to participate in voluntary wellness programs); publication bias (programs that do not show significant results are not selected for publication); the variability over time of employee participation in WWPs;[70] and difficulty in controlling for increasing medical care costs and an aging population over the course of the study.[71]

Notwithstanding these limitations, this paper evaluates the magnitude of medical cost savings under these programs. A quasi-systematic review of the literature was performed by reviewing seven systematic reviews of the cost effectiveness of WWPs. These were used to generate a list of underlying studies. The systematic reviews are listed on Exhibit 1.

Studies were selected for evaluation if they had a publication date on or after 2000 and presented data for direct medical cost savings of WWPs in the United States. There was significant overlap in the studies underlying the systematic reviews, resulting in a total of 12 studies that met the selection criteria for this paper. References to these articles are listed on Exhibit 1. Cost data were adjusted to represent 2012 values, using the US Medical Cost Inflation Factors 1935-2012, a component of the CPI-U index.

A chart presenting summary findings from these 12 studies is shown on Exhibit 2. The studies reveal a wide range of results, ranging from annual savings of $843 per employee to an annual cost increase of $311 per employee. The mean savings was $358 per employee per year, and the median was $385 per employee per year. Although researchers frequently recite an improvement in cost savings as a WWP matures, there was no apparent correlation between the length of the study period and the magnitude of savings. Based on this data, however, it might be difficult for an employer to cost- justify incentives in the magnitude of $1950 to $3250 per year, as permitted by the ACA.

PART IV: APPLICATION OF THE LAW AND THE SCIENCE TO WPP FEATURES

As Parts II and III have shown, the application of the federal employment discrimination laws to WWPs creates a patchwork of similar but inconsistent requirements for these programs, and the evidence of their effectiveness in improving health and reducing costs is similarly inconclusive. At the same time, the popularity of WWPs and the use of incentives continue to grow,

and significant growth in the future is expected.[72] This Part IV synthesizes the requirements of these laws and proposes a moderate or best practices approach to the use of incentives with respect to some of the most common WWP features. In addition, the Compliance Guide that accompanies this paper provides a checklist of the various requirements and explains the legal basis for each requirement in layman's terms. More aggressive approaches than those suggested here may be possible, but they may lead to exposure to liability under one or more of these laws.

Health Risk Assessments – The suggested guidelines for HRAs depend on whether or not the instrument is likely to elicit genetic information or family medical histories:

With genetic information or family medical history –

- The HRA may not be presented to the employee prior to or in connection with enrollment in the employer's ESHI plan.
- If incentives are offered to complete the HRA, it should be organized in two parts, with one of those parts dedicated to questions expected to elicit genetic information, including family medical history. Employees must be provided with notice that completion of this part is not required, and that the incentive will be awarded whether or not this part is completed.
- If genetic information obtained from the HRA makes the employee eligible for enhanced benefits (such as incentives to participate in a disease management/prevention program), the same benefits must be provided to employees who are at risk of the same condition because of lifestyle or other factors, and to those who have already manifested the condition. An employee who becomes eligible for the enhanced benefits due to genetic information must initiate a request to receive these benefits. To meet these rules, the employer should develop communication materials describing the enhanced benefits and instructing the employee how to make a request. A template for this notice is included in the

Compliance Guide. The enhanced benefits should also be described in the ESHI plan summary so that employees who become eligible for the benefit because they have been diagnosed with or are otherwise at risk for the condition will be aware of the enhanced benefits. However, it is not necessary for these employees to initiate a request for the benefits.

Without genetic information or family medical history –

- The completion of the HRA must be voluntary. Incentives should be structured as rewards rather than as penalties. They should be proportional to the expected benefits of completing the HRA and consistent with underwriting practices. In this regard, research indicates that incentives in excess of $100 show diminishing returns.

Biometric Standards –

- Rigid, one-size-fits-all standards should be avoided. One or more protected factors – race, sex, age, disability, and health status including genetic risk – may alone or in combination with other factors create the need for more flexibility in order to avoid prohibited discrimination.
- Where the inability to meet a standard is unreasonably difficult due to a medical condition, or if it would be medically inadvisable for an employee to attempt to satisfy the standard, the employer must work with the employee to develop a reasonable alternative. Employees must be informed of the availability of alternative standards under these circumstances. Model language for the notice is included in the Compliance Guide.
- An employer that wishes to develop best practices should develop individualized, incremental goals based on maintaining or reducing current risk levels. In this

regard, research indicates that maintaining or reducing current risk levels may produce greater healthcare cost savings than absolute changes in biometrics.

- Incentives should be proportional to expected cost savings and consistent with underwriting practices. In this regard, research does not conclusively support the premise that incentives induce long term changes in health behaviors.
- To meet requirements under ADEA, employers must ensure that cumulative incentives when combined with other plan cost-sharing features do not exceed cost-justification limits when applied to older employees.

Exercise Programs –

- Programs that structure participation requirements in terms of amount or frequency of activity should be reasonable and consistent with established guidelines. The US Department of Health and Human Services recommends 30 minutes of moderate exercise, five times per week is appropriate for health benefits.
- Required types or intensity of exercise, including fitness or performance goals, should be individually tailored and/or based on incremental goals.
- Incentives should be proportional to expected cost savings and consistent with underwriting practices.
- Employers must ensure that cumulative incentives when combined with other plan cost-sharing features do not exceed cost-justification limits when applied to older employees.
- Individual accommodations must be made for employees whose disability prevents or restricts participation in the program.
- Similarly, reasonable alternatives must be developed for employees for whom it is unreasonably difficult to participate at the required level due to a medical condition,

or for whom it would be medically inadvisable to attempt to satisfy program requirements. Employees must be informed of the availability of alternative standards under these circumstances. Model language for the notice is included in the Compliance Guide.

- If particular classes are required, the employer must pay the cost of the classes.

Diet/Nutrition Programs –

- If the program establishes weight loss or BMI standards, such standards should be individually tailored and focus on incremental goals.
- Reasonable alternatives must be developed for employees for whom it is unreasonably difficult to meet a weight loss goal or BMI measurement due to a medical condition, or for whom it would be medically inadvisable to attempt to satisfy the standards. Employees must be informed of the availability of alternative standards under these circumstances. Model language for the notice is included in the Compliance Guide.
- Incentives should be proportional to expected cost savings and consistent with underwriting practices.
- Employers must ensure that cumulative incentives when combined with other plan cost-sharing features do not exceed cost-justification limits when applied to older employees.
- If participation in a particular program is required, the employer must pay the program costs. The employer is not required to pay the costs of food.

PART V: CONCLUSION

While the ACA provisions allowing significant WWP incentives seem to evidence strong federal policy support for the idea that employees should be encouraged to adopt healthier lifestyles, it would be a mistake for employers to ignore the substantial body of federal law that protects employees from discrimination. These laws collectively temper the employer's ability to impose unreasonable and unattainable health standards on individual employees within a protected class. This is particularly true in an environment where economic pressure on employers to provide affordable health care benefits will escalate in 2014 when the ACA employer mandates come into effect.

To date, it appears that most employers have used restraint in imposing or awarding incentives under their WWPs: indeed, in issuing the ACA Proposed Regulations, the Departments justified their lack of rigorous programmatic requirements on the evidence that employers currently offer incentives in the range of $152 to $557 per year – or just three to 11 percent of the cost of coverage:

> This suggests that companies typically are not close to reaching the 20 percent … threshold [under the HIPAA regulations.] These findings indicate that based on currently available data, increasing the maximum reward for participating in a health-contingent wellness program to 30 percent … is unlikely to have a significant impact. [73]

However, the Departments' analysis did not evaluate the potential impact of the other ACA provisions that will come into effect at the same time as the WWP provisions. In 2014, employers become subject to the mandate to provide health insurance to employees at affordable rates. Coupled with surveys that show employers intend to significantly increase their use of incentives for health-contingent outcomes – particularly in the form of penalties – it appears that many employers expect to become more aggressive in their WWP plan designs.[74]

Although the reach of the federal employment discrimination laws as applied to WWPs has not yet been tested, more aggressive plan designs are likely to draw closer scrutiny. It is not clear

how sympathetic courts will be to claims of discrimination on this basis, but it would be prudent for employers to take a balanced approach to the use of incentives to further legitimate health goals by keeping incentives proportional to the anticipated benefits to be gained.

Exhibit 1:

Systematic Reviews/Sources for Articles

Systematic Reviews

Mattke S, Schnyer C, Van Busum. A review of the workplace wellness market. The Rand Corporation, for the US Department of Labor and US Department of Helath and Human Services (2012)

Osilla K, Van Busum K, Schnyer C, Larkin J, Eibner C, Mattke S. Systematic review of the impact of worksite wellness programs. *American Journal Managed Care* (Feb. 2012) 18(2); e68-e81.

Baicker K, Cutler D Song Z. Workplace wellness programs can generate savings. *Health Affairs* (Feb. 2010) 29(2).

Pelletier K. A review and analysis of the clinical and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: Update VIII 2008 to 2010. *Journal of Occupational and Environmental Medicine* (Nov. 2011) 53(11) 1310- 1331.

Pelletier K. A review and analysis of the clinical and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: Update VII 2004 to 2008. *Journal of Occupational and Environmental Medicine* (July 2009) 51: 822-837.

Pelletier K. A review and analysis of the clinical and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: Update VI 2000 to 2004. *Journal of Occupational and Environmental Medicine* (Oct 2005) 47: 1051-1058.

Chapman L. Meta-evaluation of worksite health promotion economic return studies: 2005 Update. *American Journal of Health Promotion* (July/Aug 2005) 1-15.

References to Articles Meeting Selection Criteria (in chronological order)

Musich S, et al. Effectiveness of health promotion programs in moderating medical costs in the USA. *Health Promotion International* (2000) 15; 5-15.

Ozminkowski R, et al. Long term impact of Johnson & Johnson's health and wellness program on health care utilization and expenditures. *Journal of Occupational and Environmental Medicine* (2002) 44; 21-29.

Serxner S, Gold D, Grossmeier J, Anderson D. The relationship between health promotion program participation and medical costs: a dose response. *Journal of Occupational and Environmental Medicine* (2003) 45: 1196-1200.

Stave G, Muchmore L, Gardner H. Quantifiable impact of the contract for health and wellness: Health behaviors, health care costs, disability and workers' compensation. *Journal of Occupational and Environmental Medicine* (2003) 45(2): 109-117.

Aldana S, Merrill R, Price K, Hardy A, Hager R. Financial Impact of a comprehensive multisite workplace health promotion program. *Preventive Medicine* (Feb. 2005) 40(2):131-137.

Long D, Parry T. An application of survival analysis to population health management program evaluation. *American Journal of Health Promotion.* (Jul/Aug 2007) 21(6): 529-533.

Naydeck B, et al. The impact of the Highmark employee wellness programs on 4-year health costs. *Journal of Occupational and Environmental Medicine* (2008) 50(2): 146-156.

Mattke S, Serxner S, Zakowski S, Jain A, Gold D. Impact of 2 employer sponsored population health management programs on medical care cost and utilization. *American Journal of Managed Care* (2009) 15; 113-120.

Milani R, Lavie C. Impact of worksite wellness intervention on cardiac risk factors and one-year health costs. *Journal of Occupational and Environmental Medicine* (2009) 104(10); 1389-1392.

Yen L, Schultz A, Schaefer C, Bloomberg S, Edington D. Long-term return on investment of an employee health enhancement program at a Midwest utility company from 1999 to 2007. *International Journal of Workplace Health Management* (2010) 3(2); 79-96.

Henke R, Goetzel R, McHugh J, Isaac F. Recent experience in health promotion at Johnson & Johnson: lower health spending, strong return on investment. *Health Affairs.* (2011) 30(3): 490-499.

Hochart C, Lang M. Impact of a comprehensive worksite wellness program on health risk, utilization and health care costs. *Population Health Management* (2011) 14(3); 111-116.

Merrill R, Hyatt B, Aldana S, Kinnersley D. Lowering employee health care costs through the Healthy Lifestyle Incentive Program. *Journal of Public Health Management Practice.* (2011) 17(3); 225-232.

Exhibit 2
Comparative Changes in Direct Medical Costs under Comprehensive Worksite Wellness Programs

Study Characteristics						Cost Data		
Pub: Author, Date	Study Size		Program features[1]	Study design[2]	Follow up period	Med cost change (PEPY)[3]	Cost data – year measured	Cost change adjusted to 2012
	Treat-ment	Control						
Ozminkowski, 2002	8927 - 18331*	None	ED, FC, HRA	C	4 yrs	($225)	1999	($372)
Serxner, 2003	13,048	13,363	HRA, N, T, W	C	4 yrs	($278)	1997	($492)
Stave, 2003	1275	2687	N,PA,STR, T	C	4 yrs	($185)	2000	($294)
Aldana 2005	6246			C	6 yrs	$0	2004	$0
Long, 2007	142	142	T, W	B	7 yrs	($285)	2003	($398)
Naydeck, 2008	1890	1890	STR, T, W	B	1 yr	($176)	2005	($226)
Mattke,2009	39,809	158962	No details	C	1 yr	+$242	2005	+$311
Milani, 2009	185	154	CNSL-gp and ind, ED, FC ,HRA	A	1 yr	($763)	2009	($843)
Yen, 2010	2036	154	ED, HRA	C	8 yrs	($96)	2007	($113)
Henke, 2011	31823	31823	CNSL –ind, ED, ENV, FC, HRA, WEB	B	7 yrs	($565)	2009	($624)
Hochart, 2011	9637	3800	CNSL – gp and ind, ED, HRA, WEB	C	3 yrs	($588)	2008	$670
Merrill, 2011	13790	5708	CNSL – gp, ED, HRA	C	5 yrs	($505)	2008	$576

[1] Program Feature Key: CNSL-counseling, Gp – group, Ind – individual; ED – educational program; ENV – environmental supports; FC –onsite fitness center; HRA – health risk assessment; N – nutrition; PA – physical activity; STR- stress management; T – tobacco cessation; W – weight management; WEB – web-based programs

[2] Study Design Key: A- Randomized control trial; B – Pre- and post-data with matched control group; C- observational, not matched control group

[3] PEPY – per employee per year

NAVIGATING THE MAZE OF FEDERAL EMPLOYMENT DISCRIMINATION LAWS UNDER WORKPLACE WELLNESS PROGRAMS – A COMPLIANCE GUIDE

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May 2013

INTRODUCTION

With the ever escalating cost of health care in recent years, employers that offer employee medical benefits are increasingly turning to workplace wellness programs (WWPs) in an attempt to control costs. A large percentage of employers that offer these programs use incentives to encourage employee participation. A 2012 survey by Towers Watson and the National Business Group on Health indicates that more than 70 percent of these plan sponsors use incentives to encourage employees to adopt healthier lifestyles, and a 2013 survey by Aon Hewitt reports that employers intend to increase their use of financial penalties for employees who fail to meet specified health standards.

The use of incentives to encourage participation in WWPs has been strongly endorsed by the Obama administration. Among other things, the health care reform legislation enacted in 2010 (the Patient Protection and Affordable Care Act, or "ACA") permits employers to offer significant incentives to employees who meet health standards established under their WWPs. If the WWP meets the requirements imposed under the ACA, these incentives can be valued as high as 30 to 50 percent of the cost of medical coverage. With the cost of employee-only coverage estimated to reach $6000 by the time the new WWP rules come into effect in 2014, these incentives may reach a value of $1800 to $3000 annually (or higher if the cost of dependent coverage is considered.)

In November 2012, the federal government issued proposed rules establishing the requirements these programs must meet in order to be able to fully utilize the new incentive guidelines. In addition to these requirements under the ACA, it is important for employers to understand that several other federal employment discrimination laws – including Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act - impose additional requirements, many of which will temper the extent to which an employer may offer the full reward or impose the maximum penalty under the new ACA guidelines.

This Compliance Guide presents the combined requirements of these laws in a checklist format designed to help employers develop a WWP that complies with these sometimes conflicting and frequently overlapping requirements. The checklist is embodied in the Table of Contents, which guides the reader to a fuller explanation of each requirement. In addition, a Glossary of Federal Employment Discrimination Laws briefly describes the obligations imposed under each law. Please note that there are many other federal as well as state laws that impact the design and operation of employee fringe benefit plans, including the federal Internal Revenue Code, the Employee Retirement Income Security Act and the Public Health Safety Act. These and other laws are not considered or included in this Guide, which focuses exclusively on federal employment discrimination laws.

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BIOMETRIC STANDARDS	**□ Avoid rigid, one-size-fits all standards. Standards should be based on individualized, incremental goals based on maintaining or reducing current risk levels.** **□ Incentives should be proportional to expected cost savings and consistent with underwriting practices.** **□ The value of incentives and other cost differentials applicable to employees over the age of 40 under the employer's health plan must not exceed the increased cost of providing benefits to this group.**	12
PHYSICAL ACTIVITY	**□ If incentives are contingent on specified fitness or performance goals, standards should be based on individualized, incremental goals.** **□ If incentives are contingent on completing a specified amount or frequency of exercise, standards should be reasonable and consistent with established guidelines.** **□ Employees with disabilities must be provided reasonable accommodations where appropriate.** **□ Incentives should be proportional to expected cost savings and consistent with underwriting practices.** **□ The value of incentives and other cost differentials applicable to employees over the age of 40 under the employer's health plan must not exceed the increased cost of providing benefits to this group.**	13
DIET/NUTRITION/WEIGHT LOSS	**□ If incentives are contingent on specified weight, adiposity or BMI measurements, standards should be based on individualized, incremental goals.** **□ Incentives should be proportional to expected cost savings and consistent with underwriting practices.** **□ If the WWP offers a reasonable alternative standard that consists of attending or completing a weight loss program, the employer must pay the cost of the classes.**	14
	Glossary of Federal Employment Discrimination Laws	15

RULES APPLICABLE TO ANY PLAN THAT OFFERS INCENTIVES TO ATTAIN A HEALTH OUTCOME: PROGRAM REQUIREMENTS	
□ The plan must be reasonably designed to promote health or prevent disease.	Well-designed Worksite Wellness Programs (WWPs) focus on programs designed to encourage employees (and dependents, where applicable) to change their health habits in order to improve their health risks. Programs frequently target: Tobacco cessation. The CDC offers a free tobacco cessation program at http://www.smokefree.gov/ Weight loss, diet and nutrition. The CDC has developed a program for healthy eating and weight loss at the worksite. Step-by-step instructions for developing the program are at http://www.cdc.gov/leanworks/ Physical inactivity. A tool kit for developing a physical activity component is available from the CDC at http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/pa-toolkit.htm. Stress reduction. Additional toolkits are available at: http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/index.htm#General Some WWPs will also include disease management programs within the employee's medical benefits plan. These programs provide clinical and educational support to employees who have been diagnosed with or are at risk for a disease or condition, with a view to reducing or preventing escalation in the severity of the condition. To be successful, a WWP requires strong organizational support and commitment from all levels of management. This will include: Support at the top levels of management A champion at the worksite to promote the program A commitment to soliciting employee input and feedback on the program Tailoring programs to the cultural and linguistic needs of each employee population The CDC offers a comprehensive guide to developing a well-designed WWP at http://www.cdc.gov/dhdsp/pubs/docs/HSC_Manual.pdf. This HealthScoreCard lists the most effective WWP practices and ranks them on the basis of their impact level and the degree of scientific evidence supporting their effectiveness. The HealthScoreCard can help you design a new program that will meet the ACA requirement to be reasonably designed to promote health or prevent disease. It also serves as a convenient tool to track the development of an organization's WWP over time.

RULES APPLICABLE TO ANY PLAN THAT OFFERS INCENTIVES TO ATTAIN A HEALTH OUTCOME: PROGRAM REQUIREMENTS	
The plan must permit employees to qualify for the incentive at least once each year.	Under the ACA rules, the WWP must allow employees to qualify for incentives at least once each year. For example, if the WWP requires an employee to be tobacco-free for 12 months in order to qualify, the employee must have a chance at least once each year to show that he or she has met the standard.
The plan must offer employees the opportunity to meet an alternative standard to qualify for the incentive if it is unreasonably difficult due to a medical condition, or if it would be medically inadvisable for an employee to attempt to satisfy the standard.	The ACA requires the plan to work with employees to develop alternative standards to qualify for an incentive if the employee's medical condition makes it unreasonably difficult or inadvisable to meet the general standard. Alternatively, the plan may waive the standard and allow the employee to obtain the reward or avoid the penalty, as applicable. Reasonable alternative standards are subject to these additional requirements: **The reasonable alternative should be developed in light of all the facts and circumstances applicable to the employee. This means that many times the reasonable alternative cannot be established in advance.** **If the reasonable alternative standard requires completion of an educational program, the plan must make the program available to the employee and pay the cost of the program. It is not considered reasonable to make the employee find a program without assistance from the plan.** **If the alternative requires an employee to comply with the recommendations of a health care professional engaged by the employer or the plan, the WWP must accommodate the recommendations of the employee's health care provider if the provider states that the plan-provided recommendations are not medically appropriate for the employee.**
The employer must provide notice to employees that reasonable alternatives are available in all materials that describe the terms of the WWP program.	The following language has been developed by the Department of Labor as model language for inclusion in plan materials that describe the WWP program. Employers are free to develop their own language if they prefer: **"Your health plan is committed to helping you achieve your best health status. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you to find a wellness program that is right for you in light of your health status."**

RULES APPLICABLE TO ANY PLAN THAT OFFERS INCENTIVES TO ATTAIN A HEALTH OUTCOME: PROGRAM REQUIREMENTS	
☐ **If the plan requires medical certification that the reasonable alternative is necessary due to an employee's health status, the requirement must be applied consistently to all similarly situated employees in a nondiscriminatory manner.**	If it is reasonable under the circumstances, the ACA permits the plan to require an employee to provide verification that a health factor makes it unreasonably difficult or medically inadvisable to attain the required standard. This may include a statement from the employee's personal physician. It will not be considered reasonable to require this verification if the medical condition of the employee is known to the plan and the employee's request for a reasonable alternative is obviously valid. Under the ADA and GINA, the employer should not be permitted access to the medical or health reason(s) for which the reasonable alternative is requested and/or approved. The requirement to provide verification should be applied consistently and in a nondiscriminatory manner to all similarly situated employees.

RULES APPLICABLE TO ANY PLAN THAT OFFERS INCENTIVES TO ATTAIN A HEALTH OUTCOME: MAXIMUM PERMISSIBLE INCENTIVES

☐ If the plan offers incentives for a program that is designed to prevent or reduce tobacco use, the total value of incentives offered under the WWP must not exceed 50 percent of the cost of coverage AND the value of the incentives offered for all programs except the tobacco use program must not exceed 30 percent.

☐ If the plan does not offer incentives for a program that is designed to prevent or reduce tobacco use, the total value of incentives offered under the WWP must not exceed 30 percent of the cost of coverage.

The ACA allows plans to offer incentives for up to 30 percent of the cost of coverage under the employer's medical plan. This total can increase if the WWP includes a program that targets tobacco use. In that case, the total value of incentives can be as high as 50 percent of the cost of coverage, provided the cumulative value of incentives for the WWP programs other than the tobacco use program does not exceed 30 percent.

The "cost of coverage" means the total cost of coverage for an employee (and dependents, where applicable) and includes both the portion paid by the employer and the employee's required contribution. If dependents can qualify for the incentives, the cost of coverage will be determined on the basis of the type of dependent coverage in which the employee is enrolled. For simplicity, this Compliance Guide refers only to employee coverage, but all principles would apply to WWPs that offer dependent coverage as well.

For example, if the cost of employee-only coverage is $6000 per year, the total value of incentives for all WWP programs (including the tobacco use program) can be as high as $3000 (50% of $6000), as long as the incentives for programs other than tobacco use do not exceed $1800 (30% of $6000).

CAUTIONARY NOTE: A WWP MAY MEET THE ACA STANDARDS FOR THE MAXIMUM INCENTIVE AMOUNT, BUT OTHER LAWS MAY LIMIT INCENTIVES TO AN AMOUNT THAT IS PROPORTIONAL TO EXPECTED BENEFITS AND CONSISTENT WITH UNDERWRITING PRACTICES. THESE ARE OUTLINED IN OTHER SECTIONS OF THIS GUIDE.

RULES APPLICABLE TO A PLAN THAT USES HEALTH RISK ASSESSMENTS: INCENTIVES

If the plan offers incentives to complete the HRA:

- **Incentives should be structured as rewards. Employees cannot be penalized for failure to take an HRA.**
- **Keep incentives proportional to the benefits expected to be gained from the use of the HRAs, and consistent with underwriting practices.**

A Health Risk Assessment or HRA is a survey of an employee's health behaviors and risk factors. The assessment may include biometric measurements as well as questions about lifestyle and behaviors. Once the employee completes the assessment, the answers are evaluated to determine areas of health risk and the employee is provided feedback that includes information about how changing lifestyle or behaviors may reduce the risk. This feedback, in conjunction with the other programs made available through the WWP, can be instrumental in effecting behavior changes in employees.

State and federal privacy laws generally prohibit employers from having access to the information an employee reports on a health risk assessment. Employers will typically use a health risk assessment tool provided by their health benefits plan provider or other outside consultants. The vendor can provide aggregate data from all employee responses, but cannot provide individualized data.

The Americans with Disabilities Act (ADA) prohibits an employer from requiring an employee (whether or not disabled) to take medical examinations. (There are some exceptions, but they do not apply to HRAs.) Since the HRA is considered to be a medical examination, the ADA limits the use of HRAs.

These limits are not entirely clear because the EEOC, the agency responsible for establishing guidelines, has not issued regulations. Until more guidance is available, this Guide recommends a conservative approach by limiting incentives to amounts proportional to the benefits expected to be gained from the use of HRAs and consistent with underwriting practices. That is, the incentives should not be larger than reasonably necessary to encourage employees to complete the HRA or out of proportion to any cost savings expected to be realized by increasing employee participation. In this regard, the research indicates that incentives of approximately $100 are effective to encourage participation, but incentives in excess of that amount provide diminishing returns.

RULES APPLICABLE TO A PLAN THAT USES HEALTH RISK ASSESSMENTS: GENETIC INFORMATION REQUIREMENTS

If the HRA elicits genetic information or family medical history:

- **Incentives cannot be offered – either as rewards or penalties – for completion of the part of the HRA that elicits genetic information or family medical history.**
- **An HRA that includes questions about genetic information or family medical history cannot be provided to employees prior to or in connection with enrollment in the medical plan.**

The Genetic Information Nondiscrimination Act (GINA) generally prohibits an employer from discriminating against employees and their dependents on the basis of their genetic information.

Under GINA, genetic information includes the results of genetic testing of an individual as well as his family medical history. The GINA rules impact WWPs that use health risk assessments because these assessments frequently ask questions about an employee's individual genetic health risks, particularly in connection with family medical history.

Under GINA, employees cannot be given a reward or a penalty for refusing to complete any HRA questions that might reasonably be expected to elicit genetic information or family medical history. If incentives are offered for completion of the HRA in general, the following additional requirements must be met:

- **The HRA instrument must be divided into two distinct documents.**
- **The portion of the HRA that does not ask for genetic information should clearly state that an employee should NOT provide any genetic information. The following language can be used:**

  In answering these questions, please do not include any genetic information. That is, do not include any family medical history or any information that is related to genetic testing, genetic services, genetic counseling or genetic disease for which you believe you may be at risk.

- **The portion of the HRA that asks for genetic information or family medical history must include clear instructions that inform the employee that any incentive provided for completion of the first part of the HRA (which does not ask for genetic information or family medical history) will be provided whether or not the employee completes the HRA that asks for genetic information or family medical history.**

In addition, GINA provides that employees cannot be required to complete any health risk assessment questions about genetic information or family medical history as a requirement to enroll in the employer's medical plan. An HRA that includes questions about this information cannot be provided to employees prior to or in connection with enrollment in the medical plan.

RULES APPLICABLE TO A PLAN THAT USES HEALTH RISK ASSESSMENTS: GENETIC INFORMATION REQUIREMENTS

If the plan offers enhanced benefits to employees who are identified as having a genetic risk of developing disease, the plan must meet these requirements:

- **Enhanced benefits must be offered to all employees identified as being at risk for the disease or condition, not just to those with genetic risks.**
- **Employees who are identified as being at risk for genetic reasons must initiate the request for the enhanced benefits.**

The WWP or a disease management component of an employer's medical plan may offer enhanced benefits designed to encourage employees at risk of developing a disease to change their health behaviors. For example, a plan might waive copays for generic blood pressure medications to encourage employees to adhere to a prescribed medication schedule in order to reduce the risk of cardiovascular disease. The plan may also provide education and counseling support to help employees change their lifestyle behaviors with respect to this condition.

If the plan offers these enhanced benefits, benefits cannot be restricted to employees who are identified as being at genetic risk for developing the disease. Other employees who have been diagnosed with the disease or those who are at risk of developing it due to various risk factors (such as weight and other biometric measurements) must also be eligible for the enhanced benefits.

In addition, employees who are identified as eligible for the enhanced benefits because of their genetic information must initiate the request for the enhanced benefits. *The employer and the plan are not permitted to initiate enrollment in the program.*

The employee can be notified of the availability of the program and given information about how to enroll. The program should also be described in the plan summary so that other employees (those who are already diagnosed with the disease or are otherwise at risk) know of its availability.

RULES APPLICABLE TO PLANS THAT OFFER INCENTIVES TO ATTAIN BIOMETRIC STANDARDS

□ Avoid rigid, one-size-fits all standards. Standards should be based on individualized, incremental goals based on maintaining or reducing current risk levels.

□ Incentives should be proportional to expected cost savings and consistent with underwriting practices.

□ The value of incentives and other cost differentials applicable to employees over the age of 40 under the employer's health plan must not exceed the increased cost of providing benefits to this group.

Some WWPs make receipt of incentives contingent on an employee attaining or maintaining specified biometric standards such as weight, BMI, blood pressure and/or cholesterol levels. Title VII, ADEA and the ADA all protect employees from discrimination in fringe benefits on the basis of sex, race, ethnic origin, age and disability. Applying these biometric standards on a rigid, one-size-fits-all basis can result in prohibited discrimination against one or more of these groups of protected employees.

In addition, some of these statutes require an employer to be able to show that standards that result in harsher treatment of a protected group must be justified by showing that the differences are a reasonable result based on the cost of providing benefits or accepted underwriting practices.

For example, the ADEA protects employees over the age of 40 and requires employers to show that age-based differences in benefits are justified by proving the increased cost of providing benefits to older employees. Incentives offered under a WWP should be aggregated with any increased costs under the medical plan (such as employee contribution levels) which are passed through to older employees, so that the total difference in benefits is justified.

To avoid claims of discriminatory treatment, standards for incentives should be based on individualized, incremental goals, and the value of incentives should be proportional to expected cost savings and consistent with underwriting practices. In this regard, research indicates that maintaining or reducing an employee's current risk levels may produce greater healthcare cost savings than absolute changes in biometrics. Research does not conclusively support the premise that incentives induce long term changes in health behaviors.

The general rules about providing reasonable alternative standards and the required notices will also apply. See the discussion at "Rules Applicable to Plans that Offer Incentives to Attain a Health Outcome: Program Requirements."

RULES APPLICABLE TO PLANS THAT OFFER INCENTIVES TO PARTICIPATE IN A PHYSICAL ACTIVITY PROGRAM

□ If incentives are contingent on specified fitness or performance goals, standards should be based on individualized, incremental goals.

□ If incentives are contingent on completing a specified amount or frequency of exercise, standards should be reasonable and consistent with established guidelines.

□ Employees with disabilities must be provided reasonable accommodations where appropriate.

□ Incentives should be proportional to expected cost savings and consistent with underwriting practices.

□ The value of incentives and other cost differentials applicable to employees over the age of 40 under the employer's health plan must not exceed the increased cost of providing benefits to this group.

Many WWPs offer incentives to employees who participate in a physical fitness program for a specified number of hours or frequency during the week. Other programs may require certain types of exercise or establish minimum intensity or distance standards, or require that employees meet certain performance goals.

These standards, like the biometric standards described above, can have a discriminatory effect if applied on a rigid basis to all employees without regard to their age, sex or possible disabilities. To the extent that the program requires specific types of exercise, level of intensity, or fitness or performance goals, incentives should be individually tailored and/or based on incremental goals in order to avoid discrimination claims. Programs that structure participation requirements in terms of amount or frequency of activity should be reasonable and consistent with established guidelines. The US Department of Health and Human Services recommends 30 minutes of moderate exercise, five times per week as appropriate for health benefits.

In addition to setting program goals on an individualized basis, employees who are disabled within the meaning of the ADA may require special accommodations to participate in an exercise program. Individual accommodations must be made for employees whose disability prevents or restricts access to or participation in the program.

To meet any cost-justification requirements, incentives should be proportional to expected cost savings and consistent with underwriting practices.

The general rules about providing reasonable alternative standards and the required notices will also apply. See the discussion at "Rules Applicable to Plans that Offer Incentives to Attain a Health Outcome: Program Requirements."

Similarly, the ADEA rules for cost justification discussed above in connection with Biometric Standards may apply.

Finally, if particular classes are required, the employer must pay the cost of the classes.

RULES APPLICABLE TO PLANS THAT OFFER INCENTIVES TO PARTICIPATE IN A DIET, NUTRITION OR WEIGHT LOSS PROGRAM

- **If incentives are contingent on specified weight, adiposity or BMI, standards should be based on individualized, incremental goals.**
- **Incentives should be proportional to expected cost savings and consistent with underwriting practices.**
- **If the WWP offers a reasonable alternative standard that consists of attending or completing a weight loss program, the employer must pay the cost of the classes.**

Many WWPs offer incentives to employees who participate in weight loss or nutrition programs. If the WWP provides incentives merely to attend nutrition education classes or motivational meetings, without any associated weight loss requirements, the programs generally are not subject to limits on incentives. They must be offered in a nondiscriminatory manner to similarly situated employees, but are not otherwise subject to strict requirements. However, if these classes are offered as a reasonable alternative to a weight loss program as discussed below, the employer must pay for the required classes.

If the WWP establishes weight, adiposity or BMI standards to qualify for incentives, these standards, like the biometric standards previously discussed, can have a discriminatory effect if applied on a rigid basis to all employees without regard to their age, sex or possible disabilities. To avoid discrimination claims, incentives should be individually tailored and/or based on incremental goals.

To meet any cost-justification requirements imposed under the employment discrimination laws, incentives should be proportional to expected cost savings and consistent with underwriting practices. In this regard, research indicates that incentives may promote short term weight loss but does not support the premise that incentives are effective to achieve or maintain weight loss on a long term basis.

The general rules about providing reasonable alternative standards and the required notices will also apply. See the discussion at “Rules Applicable to Plans that Offer Incentives to Attain a Health Outcome: Program Requirements.” If the reasonable alternative standard is to attend a weight loss program, the employer must pay for the cost of the classes (but not for the cost of food).

GLOSSARY OF FEDERAL EMPLOYMENT DISCRIMINATION LAWS

ACA – The Patient Protection and Affordable Care Act of 2010. This statute continues the provisions which were originally established under HIPAA to protect against discrimination in health insurance on the basis of health factors such as pre-existing conditions, physical and mental health status, medical claims costs, etc. It also continues and expands HIPAA's permissible use of incentives to encourage employees to participate in worksite wellness programs (WWPs). The ACA imposes requirements on the terms and conditions of WWPs so that the incentives cannot be used to avoid other provisions of the ACA which prohibit employers from charging an employee a higher premium or provide lower medical benefits on the basis of his or her health factors. The ACA rules include limits on the maximum amount of incentives that can be offered and requirements that: the WWP must be reasonably designed to promote health or prevent disease; employees must be given an opportunity to qualify for incentives at least once a year; and the WWP must allow employees to qualify for the incentives under a reasonable alternative if it is unreasonably difficult for an employee to participate at the required level due to a medical condition, or for whom it would be medically inadvisable to attempt to satisfy program requirements.

ADA – The Americans with Disabilities Act. The ADA protects disabled employees from employment discrimination, including discrimination in fringe benefits such as a WWP or employer-sponsored medical plan. The ADA limits the employer's rights to require employees (whether disabled or not) from undergoing medical examinations that are not job-related and necessary for business purposes. This impacts the extent to which WWPs can offer incentives for health risk assessments (which are considered to be medical examinations) and require that employees meet biometric standards (since taking the biometric measurement is a medical examination.) In addition, the ADA requires employers to make reasonable accommodations for disabled employees so that they will have the same opportunity to earn incentives. Although the general rules under the ADA prohibit an employer from discriminating on the basis of disability under its employee benefit programs, an exception to the general rule allows employer-sponsored health plans to make benefit distinctions on the basis of disability if the distinctions are cost-justified and/or consistent with underwriting practices.

ADEA – The Age Discrimination in Employment Act. The ADEA protects employees over the age of 40 from job discrimination, which generally includes discrimination in fringe benefits. However, the ADEA allows an employer to provide reduced benefits, or to charge older employees more for the same benefits, if the employer can show that the reduction in benefits or higher charge is justified on the basis of the employer's higher costs for providing these benefits to an older employee. The incentives payable under a WWP will be subject to the same rules.

GINA – The Genetic Information and Nondiscrimination Act. GINA prohibits employers from discriminating against employees on the basis of their genetic health information. Genetic information is defined to include, among other things, the results of genetic testing for the employee and his family members. An employee's genetic information includes his family medical history. An employer may not require an employee to provide genetic information, and it cannot provide incentives to encourage the employee to provide it. Also, to make sure that the employer does not use genetic information in

establishing medical benefits or premiums, the employer may not ask the employee to provide genetic information at any time prior to or in connection with enrollment in the medical plan.

Title VII – Title VII of the Civil Rights Act. Title VII prohibits employment discrimination on the basis of sex, race, religion or ethnic origin, including discrimination in fringe benefits. If benefits under a WWP or medical plan are found to be less favorable for – or if penalties are harsher when applied to – employees on this basis, the employer will be considered in violation of Title VII.

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[1] Volk J, Corlette S. Premium incentives to drive wellness in the workplace: A review of the issues and recommendations for policymakers. Georgetown University Health Policy Institute Publications (Feb 2012), available at http://chir.georgetown.edu/publications.html. Accessed March 9, 2013.
[2] Emerman E. New health care survey finds spending on wellness incentives has doubled in the last four years. Feb 27, 2013. Available at http://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=207. Accessed March 9, 2013.
[3] Burd, S. How Safeway is cutting health-care costs: Market-based solutions can reduce the national health-care bill by 40%. The Wall Street Journal. June 12, 2009. Available at http://online.wsj.com/article/SB124476804026308603.html, accessed March 9, 2013.
[4] Hilzenrath, D. A success story that isn't shapes health-care debate. The Washington Post (Jan 17, 2010). Available at http://articles.washingtonpost.com/2010-01-17/business/36834314_1_burd-health-care-costs-health-care-costs, accessed March 9, 2013.
[5] Crossley M. Discrimination against the unhealthy in health insurance. University of Kansas Law Review (2005) 54; 73-117.
[6] Public Law 104-191
[7] 42 U.S.C. 300-gg-1(b)(1)
[8] 42 U.S.C. 300-gg-1(b)(2)(B)
[9] 71 Fed Reg 75014, Dec 13, 2006
[10] 26 CFR 54.9802-1(d), 29 CFR 2590.702(d), 45 CFR 146.121(d)
[11] 71 Fed Reg 75019
[12] 71 Fe Reg 75018
[13] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 FR 70619, Nov. 26, 2012.
[14] 42 USC 2000e
[15] *Griggs v. Duke Power Company,* 401 US 424 (1971)
[16] *General Electric Co.v, Gilbert,*429 US 125 (1976)(disability insurance plan that excluded benefits for pregnancy was not discriminatory on the basis of sex)
[17] *See Saks v. Franklin Covey Co.*, 336 F 3d 337 (2d Cir. 2003)(PDA protection against pregnancy discrimination is based on pregnancy being unique to women).
[18] *Id (*exclusion for surgical implantation procedures not discriminatory because infertility could arise from male's medical condition, even though financial liability would fall on woman who undergoes procedure; court did not consider a disparate impact theory). *Also see Krauel V. Iowa Methodist Medical Center,* 95 F 3d 674 (8th Cir. 1996)(exclusion for infertility treatments not discriminatory because infertility affects men as well as women; plaintiff did not provide sufficient statistical evidence to make prima facie case for disparate impact).
[19] *Hall v. Nalco*, 534 F 3d 644 (7th Cir 2008)
[20] *See* Recent cases: Employment law - Title VII - Seventh Circuit allows employee terminated for undergoing in vitro fertilization to bring sex discrimination claim. - *Hall v.Nalco Co.,* 534 F.3d 644 (7th Cir. 2008**).** 122 *Harvard Law Review* 1533; 2008-2009
[21] 42 USC 2000e-2(k)(1)(A)(i)
[22] *Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983)

[23] *Wambheim v. J.C. Penney Co.,* 705 F 2d 1492 (9th Cir. 1983)(cost considerations are a legitimate business reason); *Krauel, supra* at note 17 (allegations that benefit structure was based on desire to save money not probative of discriminatory intent).
[24] 42 USC 12101, *et seq*.
[25] Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, as Amended, 74 Fed Reg 48431 at 48432. Sept 23, 2009.
[26] *Lowe v. American Eurocopter, LLC*, 2010 WL 5232523 (N.D. Miss. Dec. 16, 2010) (denying motion to dismiss on coverage where plaintiff had severe obesity); *EEOC v. Resources for Human Dev., Inc.*, 2011 WL 6091560 (E.D. La. Dec. 7, 2011) (denying summary judgment where plaintiff had severe obesity; plaintiff is not required to show that her obesity had a physiological basis); Rohr v. Salt River Project Agricultural Improvement and Power District, 9th Cir., No. 06-16527, 2009)(diabetes is a disability; decided prior to effective date of ADAAA but court looked to language of the amendment in reaching its decision.
[27] 42 USC 12112(d)
[28] 42 USC 12112(d)(4)(B)
[29] EEOC Opinion Letter, Mar 6, 2009
[30] EEOC Opinion Letter, Aug 10, 2009
[31] EEOC Opinion Letter, Mar 6, 2009, *rescinding* EEOC Opinion Letter Jan 6,2009
[32] EEOC Discussion Letter, Jun 24, 2011 "ADA & GINA: Incentives for workplace wellness programs."
[33] 42 USC 12112(a).
[34] 29 CFR 1630.4(f)
[35] 42 USC 12201(c)
[36] EEOC Notice 915.002, June 8, 1993. Interim Enforcement Guidance on the application of the Americans with Disabilities Act of 1990 to disability-based distinctions in employer provided health insurance.
[37] *Id.*
[38] *See, e.g., Krauel v. Iowa Methodist Medical Center*, 95 F 3d 674 (8th Cir. 1996)(medical plan exclusion for infertility treatments not prohibited)
[39] Proposed HHS Regulation Section 146.121(f)(3).
[40] *Seff v. Broward Co.*, 778 F. Supp 2d 1370 (S.D.Fla. 2011), *aff'd.* No. 11-12217 (11th Cir. Aug.20, 2012).
[41] Id. at 6 (emphasis added)
[42] 29 C.F.R. § 1625.10(d) (1989)
[43] 492 U.S. 158, 109 S.Ct. 2854 (1989)
[44] S.Rep. No. 101-263, at 18 (1990)
[45] *Modderno v. King*, 82 F 3d 1059 (D.C. Cir. 1996)
[46] 42 USC 2000ff *et seq.*
[47] Regulations under the Genetic Information Nondiscrimination Act of 2008,
75 Fed Reg 68912, Nov 9, 2010.
[48] GINA Sections 101(c), 202(b)
[49] Prohibiting Discrimination Based on Genetic Information; Interim Final Rules; HIPAA Administrative Simplification; Genetic Information Nondiscrimination Act; Proposed Rules , 74 Fed Reg 51664, Oct 9, 2009.
[50] 29 CFR 2590.702-1(d)(2)
[51] *Id.* at 51669
[52] 29 CFR 1635.8(b)(2)(iii)
[53] 29 CFR 2590.702-1(d)(3), Example 4; 29 CFR 2590.702-1(e), Example 4.
[54] Pasco J, Nicholson G, Brennan S, Kotowicz M. Prevalence of obesity and the relationship between the body mass index and body fat: Cross-sectional, population based data. *PLoS ONE* (Jan 2012) 7(1): e29850. Doi:10.1371/journal.pone.0029580.
[55] Carroll M, Kit B, Lacher D. Total and high-density lipoprotein cholesterol in adults: National Health and Nutrition Examination Survey, 2009-2010. *NCHS Data Brief* no. 92 (April 2012).
[56] Fryar C, Hirsch R, Eberhardt M, Yoon S, Wright J. Hypertension, high serum cholesterol and diabetes: Racial and ethnic prevalence differences in U.S. adults, 1999-2006. *NCHS Data Brief* no. 36 (April 2010).

[57] Pater C. The blood pressure "uncertainty range" – a pragmatic approach to overcome current diagnostic uncertainties (II). *Current Controlled trials in Cardiovascular Medicine*. (2005) doi:10.1186/1468-6708-6-5. Available at http://cvm.controlled-trials.com/content/6/1/5, accessed February 12, 2013.
[58] Taylor B, Wilt T, Welch HG. Impact of diastolic and systolic blood pressure on mortality: Implications for the definition of "normal." *Journal of General Internal Medicine* (July 2011) 26(7); 685-690.
[59] Seaverson E, Grossmeier J, Miller T, Anderson D. The role of incentive design, incentive value, communications strategy, and worksite culture on health risk assessment participation. *American Journal of Health Promotion*. (2009): 23(5) 343-352.
[60] Taitel M, Haufle V, Heck D, Loeppke R, Fetterolf d. Incentives and other factors associated with employee participation in health risk assessments. *Journal of Occupational and Environmental Medicine* (2008); 50(8) 863-872.
[61] Cahill K, Perera R. Competitions and incentives for smoking cessation (Review). *The Cochrane Library* 2009(3). Available at http://www.thecochranelibrary.com/userfiles/ccoch/file/World%20No%20Tobacco%20Day/CD004307.pdf, accessed March 31, 2013.
[62] Volpp K, Troxel A, Pauly M, Glick H, Puig A, Asch D, et al. A randomized controlled trial of financial incentives for smoking cessation. *New England Journal of Medicine.* (2009) 360(7) 699-709.
[63] Paul-Ebhohimhen V, Avenall A. Systematic review of the use of financial incentives in treatments for obesity and overweight. *Obesity Reviews.* (2007) 9; 355-367.
[64] Volpp K, John L, Troxel A, Norton L, Fassbender J, Loewenstein G. Financial incentive-based approaches for weight loss. *Journal of the American Medical Association* (2008) 300(22); 2631-2637.
[65] Moller A, McFadden HG, Hedeker D, Spring B. Financial motivation undermines maintenance in an intensive diet and activity intervention. *Journal of Obesity* (2012) Article ID 745019, doi:10.1155/2012/740519.
[66] Moriarty J, Branda M, Olsen K, Shah N, Borah B, Wagie A, Egginton J, Naessens J. The effects of incremental costs of smoking and obesity on health care costs among adults: A 7-year longitudinal study. *Journal of Occupational and Environmental Medicine.* (March 2012) 54(3); 286-291.
[67] Carls G, Goetzel R, Henke R, Bruno J, Isaac F, McHugh J. The impact of weight gain or loss on health care costs for employees at the Johnson & Johnson Family of Companies. *Journal of Occupational and Environmental Medicine* (2011) 52(1); 8-16.
[68] Finkelstein F, Linnan L, Tate D, Leese P. A longitudinal study on the relationship between weight loss, medical expenditures and absenteeism among overweight employees in the WAY to Health study. *Journal of Occupational and Environmental Health* (2009) 51; 1367-1373.
[69] Mattke S, Serxner S, Zakowski S, Jain A, Gold D. Impact of 2 employer sponsored population health management programs on medical care cost and utilization. *American Journal of Managed Care* (2009) 15; 113-120
[70] Long D, Parry T. An application of survival analysis to population health management program evaluation. *American Journal of Health Promotion.* (Jul/Aug 2007) 21(6): 529-533
[71] Musich S, et al. Effectiveness of health promotion programs in moderating medical costs in the USA. *Health Promotion International* (2000) 15; 5-15
[72] 17th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care. 2012. Available at http://www.changehealthcare.com/downloads/industry/Towers-Watson-NBGH-2012.pdf, accessed March 31, 2013.
[73] Preamble to Proposed Regulations: Incentives fo nondiscriminatory wellness programs in group health plans. 77 FR at 70629.
[74] 2012 Health Care Survey, Aon Hewitt. Available at http://www.aon.com/attachments/human-capital-consulting/2012_Health_Care_Survey_final.pdf, accessed April 1, 2013.