Wellness Programs: Selected Legal Issues

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Summary

Health care costs have risen dramatically in recent years and employers providing health insurance, as well as other insurance providers, have struggled to find ways to contain costs. This has led to the introduction of incentives to promote healthy behaviors, often referred to as wellness programs. These programs take a myriad of forms from providing a gym at the workplace to subsidizing the co-pays of certain medications and linking health care benefits or discounts to certain healthy lifestyles. In Arkansas, for example, state employees who exercise more frequently or eat healthier foods can earn up to three extra days off from work each year. These healthy lifestyle programs can include requirements for no tobacco use as well as requirements for certain cholesterol, blood pressure, or body mass index (BMI) measurements. For example, Scotts Miracle-Gro, a lawn care company, announced a policy that any smoking by employees, whether on or off the job, would result in termination of employment.

There is a wide variety of wellness programs and the application of existing law to a particular program is highly fact specific. One of the key distinctions is whether the health insurance program is provided by an individual's employer or whether it is provided by another source such as Medicaid. An employer-provided wellness program raises potential discrimination issues since, if the employer obtains information about a health condition, there could be impacts not only on the provision of insurance but also on employment.

The health care reform law, the Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148, as modified by the Health Care and Education Reconciliation Act, P.L. 111-152), significantly reformed the private health insurance market and included provisions on the implementation of employer wellness programs. This report will examine the legal issues raised by wellness programs, including discussions of PPACA, the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules, the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA), other employment discrimination laws such as the Age Discrimination in Employment Act and Title VII of the Civil Rights Act of 1964, as well as Medicaid and applicable tax code provisions.

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Introduction

Health care costs have risen dramatically in recent years[1] and employers providing health insurance, as well as other insurance providers, have struggled to find ways to contain costs. This has led to the introduction of incentives to promote healthy behaviors, often referred to as wellness programs. These programs take a myriad of forms from providing a gym at the workplace to subsidizing the co-pays of certain medications and linking health care benefits or discounts to certain healthy lifestyles. In Arkansas, for example, state employees who exercise more frequently or eat healthier foods can earn up to three extra days off from work each year.[2] These healthy lifestyle programs can include requirements for no tobacco use as well as requirements for certain cholesterol, blood pressure, or body mass index (BMI) measurements.[3] For example, Scotts Miracle-Gro, a lawn care company, announced a policy that any smoking by employees, whether on or off the job, would result in termination of employment.[4]

There is a wide variety of wellness programs and the application of existing law to a particular program is highly fact specific. One of the key distinctions is whether the health insurance program is provided by an individual's employer or whether it is provided by another source such as Medicaid. An employer-provided wellness program raises potential discrimination issues since, if the employer obtains information about a health condition, there could be impacts not only on the provision of insurance but also on employment.

The health care reform law, the Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148, as modified by the Health Care and Education Reconciliation Act, P.L. 111-152), significantly reformed the private health insurance market and included provisions on the implementation of employer wellness programs. This report will examine the legal issues raised by wellness programs, including discussions of PPACA, the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules, the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA), other employment discrimination laws such as the Age Discrimination in Employment Act and Title VII of the Civil Rights Act of 1964, as well as Medicaid and applicable tax code provisions.[5]

Patient Protection and Affordable Care Act (PPACA)

PPACA, among other things, created a number of significant reforms to the private health insurance market.[6] These reforms include changes that will limit the ability of a group health plan

[1] For a discussion of the health costs of chronic diseases, see http://www.cdc.gov/NCCdphp/overview.htm.

[2] National Conference of State Legislatures, *State Employee Health Benefits* (Updated February 28, 2010).

[3] For a discussion of these types of wellness programs, see Lucinda Jesson, "Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations," 15 Va. J. Soc. Policy and Law 217 (2008).

[4] *Id.*

[5] State statutes, such as smokers' rights laws, are beyond the scope of this report. One commentator has noted that 27 states and the District of Columbia prohibit employment discrimination based on smoking while not on the job. See Lucinda Jesson, "Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations," 15 Va. J. Soc. Policy and Law 217 (2008).

[6] For a more detailed discussion of PPACA see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind et al.

or health insurance issuer to set premiums or determine eligibility for coverage based on criteria such as health status. PPACA also contains several provisions specifically relating to wellness programs.[7] These provisions include

- PPACA §1001, which creates a new §2717 in the Public Health Services Act (PHSA) concerning reporting requirements for group health plans;
- PPACA §1201, which creates a new §2705 in the PHSA prohibiting discrimination on the basis of health status;
- PPACA §4303, amended by §10404 of P.L. 111-152, creates sections in the PHSA, including section 399MM, which provides for Centers for Disease Control (CDC) grants for employer-based wellness programs; and
- PPACA §10408, concerning workplace wellness grants.[8]

As discussed below, Section 1201 of PPACA in large part codified existing HIPAA wellness program regulations. The other three PPACA sections, PPACA §§1001, 4303, and 10408, all encourage the provision of wellness programs.

Health Insurance Portability and Accountability Act (HIPAA)[9]

Prior to the enactment of PPACA, Title I of the Health Insurance Portability and Accountability Act (HIPAA)[10] amended the Employee Retirement Income Security Act (ERISA),[11] the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) to improve portability and continuity of health coverage.[12] Among the provisions relating to health coverage, HIPAA established certain nondiscrimination requirements, which are intended to prevent group health plans[13] and group health insurance issuers[14] from discriminating against individual participants or

[7] For a more detailed discussion of these provisions, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams.

[8] For a discussion of all the PPACA provisions relating to prevention and wellness, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams.

[9] This section was written by Jennifer Staman.

[10] P.L. 104-191, 110 Stat. 1936 (Aug. 21, 1996).

[11] While not addressed in this report, ERISA may affect the operation of wellness programs, aside from the provisions discussed in this section. For example, ERISA imposes certain obligations on plan fiduciaries, persons who are generally responsible for the management and operation of employee benefit plans. See 29 U.S.C. § 1101 *et seq.* In addition, ERISA contains a remedial scheme under which participants and beneficiaries may be able to bring suit for certain ERISA violations. See 29 U.S.C. § 1132(a). If a wellness program is offered as part of a group health plan under ERISA, then these sections of ERISA may apply to the programs. For a general discussion of ERISA, see CRS Report RL34443, *Summary of the Employee Retirement Income Security Act (ERISA)*, by Patrick Purcell and Jennifer Staman.

[12] It is important to note that the provisions of ERISA, the PHSA, and the IRC cover different health plans. In general, while ERISA covers private-sector employee benefit plans and health insurance issuers, it does not cover governmental plans, church plans, or plans with fewer than two participants. The PHSA covers both group health plans and health insurance issuers in the group and the individual market, as well as some governmental plans. The IRC covers group health plans, including church plans, but does not cover health insurance issuers.

[13] A group health plan is defined by ERISA and the PHSA as a plan established or maintained by an employer, to the (continued...)

beneficiaries based on a health factor. In particular, HIPAA prohibits a group health plan or health insurance issuer from basing coverage eligibility rules on health-related factors including health status (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.[15] In addition, a group health plan or health insurance issuer may not require that an individual pay a higher premium or contribution than another "similarly situated"[16] participant, based on these health-related factors.[17] However, HIPAA contains an exception to this requirement, in that it "do[es] not prevent a group health plan and a health insurance issuer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention (i.e., wellness programs)."[18] On December 13, 2006, the Departments of Labor, Treasury, and Health and Human Services issued joint final regulations on the nondiscrimination provisions of HIPAA that provide a framework for structuring wellness programs.[19] The regulations explain that a group health plan or health insurance issuer may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment, or coinsurance), based on whether an individual has met the requirements of a wellness program that satisfies various requirements.[20]

The regulations classify wellness programs into two basic types. First, if a wellness program provides incentives based solely on participation in a wellness program, or if the wellness program does not provide a reward, the program complies with HIPAA nondiscrimination requirements without having to satisfy any additional standards, as long as the program is made available to all similarly situated individuals.[21] Examples provided in the regulations include programs that reimburse all or part of the cost for memberships in a fitness center, reimburse employees for the costs of smoking cessation programs without regard to whether the employee

(...continued)

extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise. See 29 U.S.C. § 1191b(a); 42 U.S.C. § 300gg-91(a). Under the IRC, the definition of group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer or employee organization to provide health care to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. 26 U.S.C. § 5000(b)(1).

[14] In general, a health insurance issuer means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance. 29 U.S.C. § 1191b(b)(2); 42 U.S.C. § 300gg-91(b)(2).

[15] 29 U.S.C. § 1182(a); 42 U.S.C. § 300gg-1(a); 26 U.S.C. § 9802(a). The regulations also establish that group health plans and health insurance issuers may establish more favorable rules for eligibility for individuals with an adverse health factor, practice referred to as benign discrimination. 29 C.F.R. § 2590.702(g); 45 C.F.R. § 146.121(g); 26 C.F.R. § 54.9802-1(g).

[16] The HIPAA regulations do not define the term "similarly situated," but do permit a plan or issuer to treat participants as two or more distinct groups of similarly situated individuals if the distinction is based on a "bona fide employment-based classification consistent with the employer's usual business practice." Bona fide classifications can include full-time versus part-time status, geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. See 29 C.F.R. § 2590.702(d)(1); 45 C.F.R. § 146.121(d)(1); 26 C.F.R. § 54.9802-1(d)(1).

[17] 29 U.S.C. § 1182(b)(1); 42 U.S.C. § 300gg-1(b)(1); 26 U.S.C. § 9802(b)(1). It should be noted that the IRC does not apply to health insurance issuers.

[18] 29 U.S.C. § 1182(b)(2)(B); 42 USC 300gg-1(b)(2)(B); 26 U.S.C. § 9802(b)(2)(B).

[19] Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75014 (Dec. 13, 2006).

[20] 29 C.F.R. § 2590.702(b)(1)(ii); 45 C.F.R. 146.121(b)(1)(ii); 26 C.F.R. § 54.9802-1(b)(1)(ii).

[21] 29 C.F.R. § 2590.702(f)(1); 45 C.F.R. § 146.121(f)(1); 26 C.F.R. § 54.9802-1(f)(1).

quits smoking, or provide a reward to employees for attending a monthly health education seminar.[22]

However, if the conditions for obtaining a reward[23] under a wellness program are based on an individual meeting a certain standard relating to a health factor, then the program must meet five requirements as set forth in the HIPAA regulations.[24] First, the reward offered by this type of wellness program must not exceed 20% of the cost of employee coverage under the plan (i.e., the amount paid by the employer and the employee for that employee for coverage).[25] The agencies have indicated that this 20% limit is designed to avoid a reward or penalty being so large that is has the effect of denying coverage or creating a heavy financial penalty on individuals who do not satisfy an initial wellness program standard.[26] Second, the program must be "reasonably designed to promote health or prevent disease." Accordingly, a program satisfies this standard "if it has a reasonable chance of improving the health of or preventing disease in participating individuals 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."[27] While the preamble to the final regulations explains that "bizarre, extreme, or illegal requirements" in a wellness program would be prohibited, it also states that there does not need to be a scientific record that the method used in the program promotes wellness. Thus, the "reasonably designed" standard is intended to allow diversity and experimentation in promoting wellness.[28]

Third, the program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.[29] Fourth, the reward under the program must be available to all similarly situated individuals. As part of this requirement, a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward must be available for any individual for whom it is "unreasonably difficult" due to a medical condition to satisfy the otherwise applicable standard or it is "medically inadvisable" to attempt to satisfy the otherwise applicable standard.[30] While the regulations provide no guidance as to what

[22] *Id.*

[23] The regulations provide that a reward can take the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (e.g., deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan (e.g., a prize). 29 C.F.R. § 2590.702(f)(2)(i); 45 C.F.R. § 146.121(f)(2)(i); 26 C.F.R. § 54.9802-1(f)(2)(i).

[24] To illustrate the distinction between the two types of wellness programs under the HIPAA regulations, a program that reimburses similarly situated individuals for a gym membership need not meet any additional requirements. Alternatively, a program that reimburses the cost of a gym membership if a certain weight loss goal is achieved must meet the additional five factors. See Susan Relland, *Legal Compliance for Wellness Programs*, Employee Benefit Plan Review (Mar. 2008).

[25] In addition to employees, if dependents (such as spouses or spouses and dependent children) participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. The cost of coverage is determined based on the total amount of contributions made by both the employer and the employee for the benefit package under which the employee and any dependents receive coverage. 29 C.F.R. § 2590.702(f)(2)(i); 45 C.F.R. § 146.121(f)(2)(i); 26 C.F.R. § 54.9802-1(f)(2)(i).

[26] 71 Fed. Reg. at 75018.

[27] The preamble to the final regulations provides that a program may fail to meet the "reasonable design" requirement if it imposes, as a condition of obtaining the reward, an overly burdensome time commitment or a requirement to engage in illegal behavior. *Id.*

[28] As an example, the preamble states that a plan or issuer could satisfy the "reasonably designed" standard by providing rewards to individuals who participated in a course of aromatherapy. *Id.*

[29] 29 C.F.R. § 2590.702(f)(2)(iii); 45 C.F.R. § 146.121(f)(2)(iii); 26 C.F.R. § 54.9802-1(f)(2)(iii).

[30] 29 C.F.R. § 2590.702(f)(2)(iv); 45 C.F.R. § 146.121(f)(2)(iv); 26 C.F.R. § 54.9802-1(f)(2)(iv).

constitutes "unreasonably difficult" or "medically inadvisable," a plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the standard. Fifth, the plan must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard).

Effective for plan years beginning on or after January 1, 2014, PPACA generally codifies the HIPAA wellness program regulations.[31] Accordingly, wellness programs that do not require the satisfaction of a standard relating to a health factor and are made available to all similarly situated individuals are not considered discriminatory. If, however, a wellness program conditions receiving a reward (such as a premium rebate) on meeting a health factor-related standard, the program must meet the five requirements included in the HIPAA regulations, including a cap on the amount of the reward. However, PPACA specifies that the available reward under these programs must be capped at 30% of the cost of the employee-only coverage under the plan, as opposed to 20% under the HIPAA regulations. In addition, under PPACA, the Secretaries of HHS, Labor, and Treasury have the discretion to increase this reward to up to 50%.[32]

It should be noted that HIPAA's nondiscrimination requirements, as amended by PPACA, will only apply if the program is offered as part of a group health plan, or through an insurer that provides group health coverage.[33] Thus, programs offered outside of a group health plan as a separate employment policy would not be subject to HIPAA's requirements.[34] However, other federal laws (e.g., the ADA) may still apply to these programs.[35]

The Americans with Disabilities Act (ADA)[36]

Statutory Overview

The Americans with Disabilities Act (ADA)[37] is a broad civil rights act prohibiting discrimination against individuals with disabilities. As stated in the act, its purpose is "to provide a clear and

[31] P.L. 111-148, § 1201 (creating section 2705 of the PHSA).

[32] The increase in the amount of the reward available has been lauded by some as encouraging behavioral change that will lead to improved health and lower costs. See Michael O'Donnell, "The Science of Health Promotion," 24 AMERICAN JOURNAL OF HEALTH PROMOTION iv (March/April 2010). However, others have argued that tying premium discounts to achieving certain health standards shifts costs to less healthy individuals who tend to be those with lower incomes. See Roni Caryn Rabin, "Could Health Overall Incentives Hurt Some?" THE NEW YORK TIMES (April 12, 2010); http://www.nytimes.com/2010/04/13/health/13land.html.

[33] It should be noted that PPACA would also require the HHS Secretary, in consultation with the Secretaries of the Treasury and Labor, to establish a 10-state pilot program in which participating states would be required to apply the wellness program provisions to health insurers in the individual market.

[34] Department of Labor Field Assistance Bulletin 2008-02 (Feb. 14, 2008), available at http://www.dol.gov/ebsa/pdf/fab2008-2.pdf.

[35] Id.

[36] This section was written by Nancy Jones.

[37] 42 U.S.C. §§12101 *et seq*. For a more detailed discussion of the ADA, see CRS Report 98-921, *The Americans with Disabilities Act (ADA): Statutory Language and Recent Issues*, by Nancy Lee Jones.

comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[38]

The threshold issue in any ADA case is whether the individual alleging discrimination is an individual with a disability. Several Supreme Court decisions have interpreted the definition of disability, generally limiting its application.[39] Since these Supreme Court interpretations, lower court decisions also interpreted the definition of disability strictly. Congress responded to these decisions by enacting the ADA Amendments Act, P.L. 110-325, which rejects the Supreme Court and lower court interpretations and amends the ADA to provide broader coverage.[40]

The ADA specifically covers employment. Title I of the ADA, as amended by the ADA Amendments Act of 2008, provides that no covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures; the hiring, advancement, or discharge of employees; employee compensation; job training; and other terms, conditions, and privileges of employment.[41] In addition, the ADA provides that the prohibition against discrimination includes medical examinations and inquiries.[42] Most significant for a discussion of wellness programs, the ADA contains specific limitations on pre-employment and post-employment inquiries. The ADA states in part that,

> A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.... A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site.[43]

Section 501 of the ADA addresses the application of the act to insurance. This section states that the ADA does not prohibit an insurer from "underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law" or "from establishing, sponsoring, observing or administering 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."[44]

The ADA and Wellness Programs

The Definition of Disability

As was noted previously, the threshold issue in any ADA case is whether the individual alleging discrimination is an individual with a disability. Although there was significant regulatory and

[38] 42 U.S.C. §12101(b)(1).

[39] *Sutton v. United Air Lines, Inc.*, 527 U.S. 471 (1999); *Murphy v. United Parcel Service, Inc.*, 527 U.S. 516 (1999); *Kirkingburg v. Albertson's Inc.*, 527 U.S. 555 (1999); *Toyota Motor Manufacturing v. Williams*, 534 U.S. 184 (2002).

[40] For a discussion of the ADA Amendments Act, see CRS Report RL34691, *The ADA Amendments Act: P.L. 110-325*, by Nancy Lee Jones.

[41] 42 U.S.C. §12112(a), as amended by P.L. 110-325, §5.

[42] 42 U.S.C. §12112(d).

[43] 42 U.S.C. §12112(d)(4).

[44] 42 U.S.C. §12201(c).

judicial interpretation of the original definition of disability in the ADA, the definition as amended by the ADA Amendments Act, P.L. 110-325, has not yet been the subject of judicial decisions and the EEOC has not yet promulgated final regulations.[45]

The language of the ADA Amendments Act and its legislative history both indicate that the definition of disability should be interpreted broadly. This could mean that obese individuals, those addicted to nicotine, or those with certain cholesterol or blood pressure measurements may be covered under the new language. Generally, such individuals had not been found to be covered under the previous definition of disability.[46] However, under the new definition, ADA issues may be raised by certain wellness programs targeting these conditions.

Legislative History and EEOC Guidance

Although, as noted above, the language of the ADA does not address wellness programs other than allowing voluntary medical examinations as part of an employment health program, its legislative history provides more guidance. The House Education and Labor Committee Report observes the following:

> A growing number of employers today are offering voluntary wellness programs in the workplace. These programs often include medical screening for high blood pressure, weight control, cancer detection, and the like. As long as the programs are voluntary and the medical records are maintained in a confidential manner and not used for the purpose of limiting health insurance eligibility or of preventing occupational advancement, these activities would fall within the purview of accepted activities.[47]

The Equal Employment Opportunity Commission (EEOC) issued guidance paralleling this legislative history and stating that an employer may make disability-related inquiries or conduct medical examinations as a part of a voluntary wellness program.[48] In its guidance, the EEOC emphasized that medical records acquired as part of the wellness program must be kept confidential and separate from personnel records and noted that "a wellness program is 'voluntary' as long as an employer neither requires participation nor penalizes employees who do not participate."[49]

The EEOC elaborated on the meaning of "voluntary" in a response to a letter asking whether a requirement that employees participate in a health risk assessment as a condition for participation in its health insurance plan violated the ADA.[50] The EEOC stated that "requiring that all employees take a health risk assessment that includes disability-related inquiries and medical examinations as a prerequisite for obtaining health insurance coverage does not appear to be job-related and consistent with business necessity, and therefore would violate the ADA."[51]

[45] Proposed regulations were published in the Federal Register on September 23, 2009. 74 FED. REG. 48431 (Sept. 23, 2009). For a discussion of these regulations see CRS Report R40875, *The Americans with Disabilities Act (ADA): Proposed Employment Regulations*, by Nancy Lee Jones.

[46] For a discussion of ADA cases on obesity prior to enactment of the ADA Amendments Act, see CRS Report RS22609, *Obesity Discrimination and the Americans with Disabilities Act*, by Jennifer Staman.

[47] H.Rept. 101-485, pt. 2, at 75 (1990).

[48] http://www.eeoc.gov/policy/docs/guidance-inquiries.html#10.

[49] *Id.*

[50] http://www.eeoc.gov/foia/letters/2009/ada_disability_medexam_healthrisk.html.

[51] *Id.*

Observing that disability-related inquiries and medical examinations are permitted as part of a voluntary wellness program, the EEOC noted that the program described was not voluntary since if an employee did not participate in the health risk assessment, he or she would not be able to obtain insurance through the employer's plan. Interestingly, the EEOC had originally sent a letter stating that a wellness program would be considered voluntary as long as the inducement to participate in the program did not exceed 20% of the cost of employee coverage under the plan—the same percentage as provided in the HIPAA regulations before PPACA. Since the question posed to the EEOC had not raised the issue of what level of inducement might be permissible under the ADA, the EEOC withdrew that portion of the letter, noting "[t]he Commission is continuing to examine what level, if any, of financial inducement to participate in a wellness program would be permissible under the ADA."[52] It is uncertain, then, what level of inducement, if any, might be permitted under the ADA and if it would differ from that allowed under PPACA.

Genetic Information Nondiscrimination Act (GINA)[53]

GINA, P.L. 110-233, prohibits discrimination based on genetic information by health insurers and employers.[54] GINA is divided into two main parts: Title I, which prohibits discrimination based on genetic information by health insurers; and Title II, which prohibits discrimination based on genetic information in employment. GINA specifically forbids an employer from requesting, requiring, or purchasing genetic information of an employee or a family member of an employee.[55] However, there are statutory exceptions relevant to wellness programs which include

> where – (A) health or genetic services are offered by the employer, including such services offered as part of a wellness program; (B) the employee provides prior, knowing, voluntary, and written authorization; (C) only the employee (or family member if the family member is receiving genetic services) and the licensed health care professional or board certified genetic counselor involved in providing such services receive individually identifiable information concerning the results of such services; and (D) any individually identifiable genetic information provided under subparagraph (C) in connection with the services provided under subparagraph (A) is only available for the purposes of such services and shall not be disclosed to the employer except in aggregate terms that do not disclose the identity of specific employees.... [56]

[52] *Id.*

[53] This section was written by Nancy Jones.

[54] For a discussion of GINA generally, see CRS Report RL34584, *The Genetic Information Nondiscrimination Act of 2008 (GINA)*, by Nancy Lee Jones and Amanda K. Sarata. For a more detailed discussion of GINA and wellness programs see CRS Report R41314, *The Genetic Information Nondiscrimination Act of 2008 and the Patient Protection and Affordable Care Act of 2010: Overview and Legal Analysis of Potential Interactions*, coordinated by Amanda K. Sarata, and CRS Report R40791, *Employer Wellness Programs: Health Reform and the Genetic Information Nondiscrimination Act*, by Amanda K. Sarata.

[55] 42 U.S.C. §2000ff-1(b). Identical requirements, including the statutory exceptions, are placed on employment agencies [42 U.S.C. §2000ff-2(b)], labor organizations [42 U.S.C. §2000ff-3(b)], and training programs [42 U.S.C. §2000ff-4(b)].

[56] 42 U.S.C. §2000ff-1(b)(2).

Thus, in order to comply with GINA, any wellness program that collects genetic information must be voluntary, must be conditioned on written authorization, and must have strict privacy protections.

In proposed regulations, the EEOC relied upon the same reasoning as it used in its interpretation of the ADA, stating that,

> GINA permits covered entities to offer health or genetic services, and notes that a covered entity that meets specific requirements may offer such services as a part of a wellness program. The proposed regulation reiterates the statutory provision, but further notes that a wellness program seeking medical information must be voluntary, which is a requirement set forth in the ADA. The Commission notes that according to the Enforcement Guidance, a wellness program is voluntary "as long as an employer neither requires participation nor penalizes employees who do not participate.... " The Commission has not further addressed how the term "voluntary" should be defined for purposes of the ADA's application to wellness programs. We invite comments regarding the scope of this term.[57]

This is similar to the ADA in that the ADA also requires voluntary participation, and as with the ADA, it is uncertain what level of inducement might be permitted. Final regulations under GINA, due out shortly, may address this issue with greater specificity. In addition, unlike the ADA, GINA contains a specific requirement for a written authorization. It should be noted, though, that the ADA does contain specific requirements for medical examinations and inquiries.[58]

Other Employment Discrimination Laws[59]

In addition to the ADA and GINA, there are several other employment discrimination laws that employers may need to consider when implementing wellness programs, including the Age Discrimination in Employment Act (ADEA) and Title VII of the Civil Rights Act of 1964.

Age Discrimination in Employment Act (ADEA)

The ADEA prohibits employment discrimination against persons over the age of 40.[60] Under the statute, it is unlawful for an employer "to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age."[61] The statute not only applies to hiring, discharge, and promotion, but also prohibits discrimination in employee benefit plans such as health coverage and pensions.

Because a wellness program would presumably constitute a health benefit for purposes of ADEA coverage, an ADEA violation may occur if a wellness program has a disparate impact on older employees. The ADEA has been held to authorize disparate impact claims, which arise when an otherwise neutral employment policy or practice has an adverse impact on a class of employees

[57] 74 FED. REG. 9062 (March 2, 2009).

[58] 42 U.S.C. 12112(d).

[59] This section was written by Jody Feder.

[60] 29 U.S.C. §§ 621 et seq.

[61] Id. at § 623.

and is not otherwise reasonable.[62] Thus, if a wellness program establishes a health standard that is more difficult for older employees to achieve, it may create a disparate impact in violation of the statute.

Title VII of the Civil Rights Act of 1964

Title VII prohibits an employer from discriminating against any individual with respect to hiring or the terms and conditions of employment because of such individual's race, color, religion, sex, or national origin.[63] Because Title VII applies to a broad range of employment practices, discrimination regarding health benefits may also violate the act. Like the ADEA, Title VII prohibits employment practices that have a disparate impact on covered individuals.[64] As a result, if a wellness program establishes a health standard that is more difficult for members of the protected classes to achieve, it may create a disparate impact in violation of Title VII.

Internal Revenue Code (IRC)[65]

Unlike the ADA or HIPAA, the IRC generally does not require or prohibit any particular conduct. Instead, it regulates private activity through the manipulation of financial incentives and disincentives in the form of an individual's tax liability. Legislative proposals to create new tax incentives for workplace wellness programs generally fall into two categories: (1) tax incentives for employees in the form of favorable tax treatment of employer-provided wellness benefits and (2) tax incentives, such as credits or deductions, to offset employers' costs inherent in establishing or maintaining a workplace wellness program.

Tax Treatment of Benefits Received by Employees

The benefits provided to an employee by a workplace wellness program may constitute taxable income under the IRC. The IRC computes the taxable income of a taxpayer by deducting certain amounts from a taxpayer's gross income. Gross income generally includes compensation provided in exchange for services.[66] This also includes amounts provided in a form other than cash.[67] Therefore, benefits provided by an employer to its employees through a wellness program appear to presumptively be included in the gross income of the employee.

Employees receiving workplace wellness benefits may attempt to rebut this presumption by arguing that those benefits should be excluded from gross income under IRC provisions such as those excluding gifts, employee achievement awards, fringe benefits, or health benefits provided by an employer. Whether or not a benefit qualifies as non-taxable income is likely to turn on factors other than any link to a workplace wellness program. In other words, the fact that a benefit is being provided as an incentive to promote an employee's health is unlikely to have any impact

[62] Smith v. City of Jackson, 544 U.S. 228 (2005).

[63] 42 U.S.C. § 2000e-2.

[64] Id. *See also*, Griggs v. Duke Power Co., 401 U.S. 424 (1971).

[65] This section was written by Edward Liu.

[66] 26 U.S.C. § 61(a)(1).

[67] Treas. Reg. § 1.61-2(d).

on whether the employee must ultimately pay taxes on the receipt of that benefit. Several tax provisions that may be relevant are discussed below. Importantly, this analysis only examines whether receipt of these benefits in the context of a workplace wellness program would constitute taxable income; other laws may prevent providing incentives or benefits in the manner described.

Gifts and Awards

Gifts are generally excluded from the recipient's gross income.[68] However, this provision explicitly does not apply to transfers from an employer to an employee.[69] Therefore, it would not be accurate to claim that a workplace wellness benefit, such as membership at an outside athletic facility or a retail gift certificate, could be excluded from an employee's gross income because it is a gift from the employer.

Prizes and awards are generally included in gross income.[70] However, the value of "employee achievement awards" are not included in the gross income of the recipient.[71] The IRS defines employee achievement awards narrowly, limiting application of this provision to awards given for length of service or safety.[72] It is unlikely that a wellness benefit could be construed as a "length of service" award, but to the extent that a wellness benefit or program could be construed as a "safety" award it may qualify for exclusion from a receiving employee's income.

Fringe Benefits

Fringe benefits received from an employer are excluded from an employee's gross income.[73] The IRC recognizes several types of fringe benefits including no-additional-cost services, qualified employee discounts, de minimis fringes, qualified transportation fringes, qualified moving expense fringes, qualified retirement planning services, and on-premises athletic facilities.[74]

Each fringe is subject to various limitations and requirements. For example, transit passes provided by an employer cannot exceed $120 per month (for tax years 2009 and on) in order to qualify as a transportation fringe.[75] Fringe benefits are not required to be provided to employees, nor are they required to be provided unconditionally. Not every workplace wellness benefit would qualify as a fringe benefit, but a workplace wellness program could offer fringe benefits (such as employee discounts or transit subsidies) as part of an incentive scheme to reward healthy behaviors without increasing employees' tax liability.

[68] 26 U.S.C. § 102(a).

[69] 26 U.S.C. § 102(c).

[70] 26 U.S.C. § 74(a).

[71] 26 U.S.C. § 74(c)(1).

[72] 26 U.S.C. § 274(j)(3)(A).

[73] 26 U.S.C. § 132.

[74] *Id.*

[75] 26 U.S.C. § 132(f)(2)(A); Rev. Proc. 2008-66, § 3.12.

Employer-Provided Health Benefits

Amounts received by employees for medical care, and health insurance premiums provided by employers, under an employer-provided health plan are excluded from employees' gross income.[76] However, this exclusion only applies to amounts provided to the employee for medical care. The IRS has also promulgated regulations indicating that benefits which only promote general health do not qualify as "medical care" for these purposes.[77] Some workplace wellness benefits (such as high blood pressure screenings or vaccinations) might qualify as medical care because they serve a diagnostic or preventive function. On the other hand, other types of benefits (such as discounts on commercial gym memberships) might not qualify. Recipients of non-qualifying benefits would be required to include the value of those benefits in gross income, if they were provided in the context of an employer-provided health plan.

Cash Incentives

Health savings accounts (HSA) and health reimbursement accounts (HRA) can provide tax-advantaged accounts to pay for qualified medical expenses.[78] Among other benefits, employer contributions to HSAs and HRAs receive favorable tax treatment. Therefore, some have suggested that workplace wellness programs could include employer contributions to HSAs or HRAs as incentives without incurring additional tax liability on the part of the recipients.

While such a scheme may not increase a participating employee's tax liability, these arrangements may result in increased tax liability for employers in the form of excise taxes. Employer contributions to an HSA must be made comparably to participating employees; failure to satisfy this comparability requirement can subject an employer to an excise tax.[79] Similarly, group health plans, including HRAs, that engage in certain types of discrimination on the basis of health status may also be subject to excise taxes.[80]

Tax Treatment of Employers' Costs

An employer's costs in creating or administering a wellness program may generally be deducted from an employer's taxable income as a business expense.[81] Additionally, identical House and Senate versions of the Healthy Workforce Act, H.R. 1897 and S. 803, have been introduced in the 111th Congress. These bills would provide an additional business credit to an employer based on amounts expended to implement a qualifying wellness program. Under either bill, a qualifying wellness program would be required to contain components addressing at least three of the

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[76] 26 U.S.C. §§ 105(b), 106.

[77] Treas. Reg. § 1.213(e)(1)(ii). "An expenditure which is merely beneficial to the *general health* of an individual, such as an expenditure for a vacation, is not an expenditure for medical care."

[78] 26 U.S.C. § 223. *See also* CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Carol Rapaport.

[79] *See* 26 U.S.C. § 4980G. Therefore, if an employer provides HSA contributions only to those employees that meet certain wellness goals, it may be subject to an excise tax.

[80] *See* 26 U.S.C. §§ 4980D, 9802. Among the types of prohibited discrimination are those prohibited by HIPAA and GINA discussed *supra*.

[81] 26 U.S.C. § 162(a).

following: health awareness, employee engagement, behavioral change, or a supportive environment.

National Labor Relations Act[82]

The National Labor Relations Act (NLRA)[83] guarantees the right to engage in collective bargaining for most private-sector employees. Once a union has been designated as the exclusive bargaining representative for a bargaining unit, both the employer and the union have an obligation to negotiate with each other in good faith.[84] Section 8(d) of the NLRA directs the parties to "confer in good faith with respect to wages, hours, and other terms and conditions of employment."[85] The National Labor Relations Board and the courts have recognized a distinction between mandatory subjects of bargaining, which reflect the language in Section 8(d), and permissive subjects, which may be negotiated at the discretion of the parties.

Health benefits are generally considered to be a mandatory subject of bargaining.[86] A wellness program, depending on how it is structured and the kinds of benefits offered, may be considered similarly to be a mandatory subject of bargaining. Thus, in a unionized environment, it would be necessary to negotiate the implementation of such a program.

Medicaid[87]

The Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.,* serves over 60 million people, and it provides health care services for some of the most vulnerable populations in the United States.[88] In an effort to improve beneficiaries' health and hold down health care costs, state Medicaid programs have increasingly emphasized prevention and wellness. To do this, states are using innovative design approaches and taking advantage of increased flexibility of federal requirements.

State public programs often serve as laboratories for testing innovative approaches to health care. Congress, in the Deficit Reduction Act of 2005, granted the states increased flexibility to use innovative approaches in their Medicaid programs to take care of the health care needs of their citizens. Data obtained from pilot or demonstration projects such as those described below can be used to help design future programs in both the public and private sectors to motivate persons to engage in healthy behaviors, improve their health, and hold down health care costs.[89]

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[82] This section was written by Jon Shimabukuro.

[83] 29 U.S.C. § 151 *et seq*.

[84] *See* 29 U.S.C. § 158(a)(5), (b)(3) (making it an unfair labor practice to refuse to bargain collectively with the exclusive representative of a bargaining unit or an employer).

[85] 29 U.S.C. § 158(d).

[86] *See* The Developing Labor Law 1274-81 (John E. Higgins et al. eds., 2006).

[87] This section was written by Kathleen Swendiman.

[88] Centers for Medicare and Medicaid, 2008 Date Compendium at http://www.cms.hhs.gov/DataCompendium/01_Overview.asp#TopOfPage.

[89] G. Bishop and A. C. Brodkey, Personal Responsibility and Physician Responsibility—West Virginia's Medicaid Plan, *New England Journal of Medicine,* August 24, 2006, 355 (8): 756; Pat Redmond, Judith Solomon, and Mark Lin, (continued...)

New Flexibility Under the Deficit Reduction Act of 2005

Traditionally, states have used the state plan waiver process authorized in Section 1115 of the Social Security Act, 42 U.S.C. § 1315, to alter their Medicaid programs to try out innovative ideas for health care coverage and delivery.[90] The waiver process is time-consuming and changes proposed through the waiver process must be budget neutral. In 2005, Congress enacted the Deficit Reduction Act of 2005 (DRA) which includes provisions making it easier for states to incorporate innovative ideas including wellness programs in their Medicaid plans without having to comply with budget neutrality requirements and going through the Section 1115 waiver process. Specifically, Section 6044 of P.L. 109-171 added a new Section 1937 to the Social Security Act allowing states to amend their Medicaid state plans to provide alternative benefit packages to beneficiaries, without regard to traditional Medicaid requirements such as comparability, statewideness, and freedom of choice. Because these changes are implemented as an amendment to the state's Medicaid plan, they do not require budget neutrality. These "benchmark plans," as they are called, include several coverage choices, as well as the option for a state to propose a plan that would have to be approved by the Department of Health and Human Services (HHS).[91]

While the DRA option provides more flexibility than the Section 1115 waiver process, there are still restrictions. Categories of individuals that can be required to enroll in an alternative Medicaid plan are generally limited to healthy adults and children. If benchmark coverage is provided to children, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services must continue to be provided to individuals under age 21. These services include comprehensive screening services (i.e., well-child visits, immunizations) as well as dental, vision, and hearing services. In addition, EPSDT guarantees access to all federally coverable services necessary to treat an identified problem or condition among eligibles.[92]

The West Virginia Pilot Program

West Virginia, one of the first states to receive approval for a DRA State Plan Amendment establishing alternative benefits, began a pilot program in 2006 offering certain Medicaid enrollees a choice of two benefit packages—a basic plan and an enhanced plan that included benefits not traditionally offered under Medicaid.[93] What sets this concept apart from other wellness programs is the fact that the enhanced plan requires the beneficiary to adhere to an

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Can Incentives for Health Behavior Improve Health and Hold Down Medicaid Costs? (Washington: Center on Budget and Policy Priorities, June 2007); Issue Brief, *Medicaid Redesigned: State Innovations in Health Coverage and Delivery,* National Governors' Association Center for Best Practices, March 27, 2008.

[90] The Section 1115 waiver process has been used by states for such purposes as expanding covered populations, incorporating new services, or using innovative delivery systems. See Medicaid State Waiver Program Demonstration Projects – General Information, Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/.

[91] Section 1937(b) of the Social Security Act, 42 U.S.C. § 1396u-7(b).

[92] EPSDT benefits are fairly broad sets of services provided to Medicaid children, 42 U.S.C. § 1396a(a)(43), 42 U.S.C. § 1396d(r).

[93] See also HHS Press Release, "HHS Approves Innovative Medicaid Reform in West Virginia," at http://www.hhs.gov/news/press/2006pres/20060503.html.

agreement or else lose access to additional health benefits such as substance abuse and mental health services.[94]

West Virginia's basic plan includes all mandatory Medicaid services. The enhanced plan provides all mandatory Medicaid services with additional optional services including wellness benefits such as tobacco cessation services, nutritional education, diabetes care, and chemical dependency and mental health services. The enhanced plan also includes skilled nursing care and orthotics/prosthetics for children. In order to enroll in the enhanced benefit plan, beneficiaries must sign an agreement stating that they will comply with all recommended medical treatment and wellness behaviors.[95] These include keeping medical appointments, getting recommended medical screenings, avoiding unnecessary emergency room visits, and taking prescribed medications. Physicians and managed care organizations monitor members' adherence to the member agreement and report to the state if the agreement is not met. If members are found not to be meeting their responsibilities, they are placed back into the Basic Medicaid plan. The West Virginia Medicaid website describes the state's "Mountain Health Choices" program as follows:

> Mountain Health Choices gives members a choice of benefit plans, requires responsibility, sets expectations for behavior and rewards success. It is designed to encourage healthy habits for all West Virginia Medicaid members. Medicaid members who sign the Member Responsibility Agreement will have access to services not provided in traditional Medicaid Benefits. By visiting their medical home for a check-up and working with their healthcare providers to set goals for health improvement, members qualify for the Enhanced Benefit Package. This package provides the opportunity for members to participate in weight management, physical activity and other educational opportunities for health improvement. Members who choose not to sign the Member Responsibility Agreement will have the Basic Benefit Package. This package covers all healthcare services which are mandated by federal and state laws. Medicaid members will have the opportunity to enroll in the Enhanced Benefit Package each year upon their date of re-determination and for 90 days after that date.[96]

Other State Medicaid Wellness Initiatives

Using the DRA flexibility and the ability to apply for Section 1115 waivers, other states have also implemented innovations aimed at engaging Medicaid beneficiaries in prevention and wellness programs. Some states are rewarding their Medicaid recipients for participating in wellness activities, such as disease management, smoking cessation, or weight loss programs. The rewards may be in the form of additional benefits not otherwise offered as part of the plan, or in the form of points to be used toward additional wellness activities. For example, in Idaho, Medicaid beneficiaries pay a monthly premium up to $15 per member. Beneficiaries can earn 30 points every three months by receiving recommended wellness visits and by keeping immunizations up-to-date. Each point equals $1 which can be used to offset premium payments.[97] Florida's

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[94] Concerns have been raised about this and other Medicaid wellness "reward/penalty" plans, including whether the plans' requirements address the various barriers low income individuals face in reaching health goals, e.g., lack of child care or transportation services needed to attend exercise classes or nutrition counseling. See *Reward/Penalty Plans for Wellness: Coming Soon to an Office Near You?* Families USA (February 2008).

[95] http://www.wvdhhr.org/bms/oAdministration/Medicaid_Redesign/redesign_MemberAgreement.pdf.

[96] http://www.wvdhhr.org/bms/oAdministration/Medicaid_Redesign/MedRedesign_main.asp. A recent report on the effectiveness of West Virginia's Mountain Health Choices program may be viewed at http://www.hsc.wvu.edu/wvhealthpolicy/reports/RWJ%20Policy%20Brief%20FINAL%2003.27.09.pdf.

[97] *See* Idaho's Preventative Health Assistance program under Medicaid at http://www.healthandwelfare.idaho.gov/ (continued...)

Medicaid program includes innovations obtained through a Section 1115 waiver. These consumer engagement provisions include enhanced benefits accounts, which offer credits for enrollees who maintain healthy behaviors.[98] Beneficiaries may use the credits for up to three years after leaving the Medicaid program, thus providing a transition out of Medicaid coverage. The credits can be used to buy things like over-the-counter medications and nutritional and smoking cessation classes.[99] Under the DRA provisions, Wisconsin has implemented pay-for-performance incentives for its BadgerCare Plus managed care programs to increase member participation in prevention and wellness programs. Plans will receive an incentive reward for increasing the percentage of smokers they help quit the habit through participation in a tobacco cessation initiative. Plans can also receive an incentive reward for increasing the percentage of members who receive appropriate dental care, and for children under 21 who receive a free health checkup that is offered.[100]

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Medical/Medicaid/PreventiveHealthAssistance/tabid/221/Default.aspx. A June 2010 report on the effectiveness of Idaho's Medicaid wellness programs may be viewed at http://www.shadac.org/files/shadac/publications/IdahoMedicaidDRACaseStudy.pdf.

[98] *Introducing the Enhanced Benefits Account Program* (Florida: Florida Agency for Health Care Administration, August 2007) at http://ahca.myflorida.com/Medicaid/Enhanced_Benefits/index.shtml.

[99] Studies are starting to be published regarding the effectiveness of these new programs. For example, see "Florida's Experience with Medicaid Reform: *The Enhanced Benefits Rewards Program: Is it changing the way Medicaid beneficiaries approach their health?*" (Georgetown University Health Policy Institute: Briefing #6), July 2008, available at http://ihcrp.georgetown.edu/floridamedicaid/pdfs/briefing6.pdf.

[100] Louise Kertesz, Renewed Focus on Prevention and Wellness in State Medicaid Programs, *AHIP Coverage,* October 10, 2008 at 2. *See* Wisconsin BadgerCare Plus Home Page at http://www.badgercareplus.org/.