Reining in Health Care Costs with Wellness Programs: Frequently Overlooked Legal Issues

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With health care costs spiraling out of control across the nation, employers are desperately seeking viable solutions to stop the tailspin. Bolstered by a growing body of convincing empirical data, wellness programs are now raising eyebrows as a valuable cost containment strategy. This article briefly reviews the current state of employer health care costs in the United States and the causes underlying their meteoric climb. The article then provides an overview of wellness programs and their potential to favorably impact the corporate bottom line. Although wellness programs historically have not been considered "health plans" from a compliance standpoint, wellness programs are raising an increasing number of legal issues for employers under ERISA, HIPAA, ADA, COBRA, and the new rules governing Health Savings Accounts (HSAs). This article highlights these legal implications, as well as briefly discussing proposed federal legislation affording tax credits and grants to foster the growth of workplace wellness programs. The article concludes by providing practical guidance on how employers can successfully design and implement a wellness program.

Companies in the United States are currently facing a health care dilemma that borders on a national catastrophe. With double-digit health care increases battering companies in recent years, most employers have absorbed significant cost hikes. As described in Figure 1, some estimate that health care costs have increased more than 50 percent in the past five years alone. To be sure, some of these costs have been passed directly on to employees in the form of increased premiums, deductibles, co-pays, and co-insurance. Employers, however, have absorbed about 77 percent of all health insurance costs since 1992.[1] Once viewed as just a "benefits" issue, health coverage for employees is now cutting painfully into corporate profits and forcing employers to re-think the way they provide health insurance.

The problem of skyrocketing health care costs is taking a toll on

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Figure 1. Annual Health Care Cost Increase per Employee, 1998–2004.

Year	Percentage Increase	Employee Cost
1998	6.1%	$3,817
1999	7.3%	$4,097
2000	8.1%	$4,430
2001	11.2%	$4,924
2002	14.7%	$5,646
2003	10.1%	$6,215
2004	12.6% (estimated)	N/A

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2003.

the nation's entire economy. According to the Centers for Medicare and Medicaid Services (CMS), per capita health care expenditures reached $5,440 in 2002, comprising 14.9 percent of the nation's gross domestic product (GDP).[2] CMS projects that by 2012 these costs will swell to $10,110[3] per person, constituting 18.1 percent of GDP.[4]

Several key factors are driving the soaring cost of health care. First, prescription drug expenses have increased at an alarming and steady rate. Direct-to-consumer drug marketing and the increasing prevalence of lifestyle drugs like Viagra and Rogaine have contributed to this escalation.[5]

Second, health costs are rising due to a retreat from tightly managed health care, which has made it easier for employees to see their doctors and visit specialists. Patients—particularly the country's aging population—have generally increased their utilization of health care services, further driving up costs. Critics worry that many employees have an "entitlement" mentality toward their health coverage. "I want it all and I want it cheap. I want the Mayo Clinic for a $10 co-pay." Because employers pay for the lion's share of health care costs, there is a fundamental "market disconnect" between the true cost of health care and the amount actually paid by the consumer. Employees typically do not know what their health care and prescription drugs really cost. This lack of transparency fosters an increased utilization of services.

Third, hospitals and providers have continued to increase prices, in part to pay for ever-advancing medical equipment and technologies. Fourth, the nature of health plans has shifted somewhat over time. During the 1950s and 1960s, health plans generally provided financial protection against catastrophic loss. Today health plans provide more comprehensive coverage. Indeed, many employees today pay less for a visit to their doctor than they do for a haircut. Finally, changes in

the Medicare program and increased government mandates have exacerbated the problem.

Amidst all this, employers are scrambling for innovative solutions. A 2004 Hewitt Study found that 96 percent of corporate executives are critically or greatly concerned about the impact of rising health care costs on their companies' bottom line, and 91 percent said its impact on their employees is of significant or critical concern. The study also found that although health care costs are projected to increase at an overall annual average of 14 percent, the maximum affordable rate for employers is closer to 9 percent. Many believe that the astronomic cost increases of recent years are simply not sustainable, and that active employer and consumer involvement (rather than national health care) is the answer.[6]

A SHIFTING TIDE

Across the country, a gradual shift toward consumerism and preventive care is taking place in the health care industry. As employees absorb more health care costs, proponents feel employees will develop a mounting awareness and concern about the cost of their health care. This awareness may spark a desire to take more responsibility for their health care decisions and better evaluate treatment options. This new consumer-focused health model has as its hallmarks greater employee involvement, greater transparency and exposure to real costs, greater access to medical information about cost and quality, greater choice of providers, and a greater focus on preventive care. It is premised on the philosophy that if given the necessary tools and information, employees will make better health care decisions about their own health than would someone else. (How often do you take a rental car down to a car wash or for an oil change?) The corollary doctrine is that employees will spend their own money more prudently than they will spend someone else's money.

As employees become more savvy consumers of health care, and health care prices become more transparent, the market theoretically will become more efficient. (Look at how the price of laser eye surgery has dropped over time.) Advocates hope that the rising tide will lift all boats, with increased efficiency and accountability spilling over into Medicare and other segments of the health care community.

The move toward consumerism and preventive care has been facilitated by significant improvements in health care technology, which puts powerful information at the fingertips of employees. Internet access and use by employees and their families is continuously increasing. A greater array of valuable tools are becoming available. These include on-line health education (WebMD-type services), prescription drug price comparisons, preventive care guidelines, health risk assessments, and 24-hour access to nurses or "health coaches."

Across the board, the health insurance industry is heavily investing in creating and refining these innovative health care technologies.

So why do wellness programs figure so vitally in all this? When employees are paying more medical expenses out of their own pocket, they will be more motivated to take better care of themselves. An employee who understands that exercising three times a week will ultimately save him money is more likely to exercise than one who's told it will merely keep his employer's health care costs down. Employees who have a heightened financial and personal interest in their own health care will begin to see value in workplace wellness programs. In the consumer-driven health plan world, it will be natural for employees to look for ways to save money on their health care costs. The result: employees may actually seek out wellness programs, rather than having to be prodded into them.

One of the reasons that wellness programs hold so much hope is because the majority of health care expenditures in America go toward treating preventable conditions.[7] Wellness programs largely focus on preventing preventable health conditions. These illnesses are attributable to and exacerbated by individual behaviors and lifestyle choices. In particular, smoking, poor diet, and lack of physical exercise greatly heighten the risk of developing the most serious chronic disorders. A relatively small number of chronic disorders account for the majority of deaths each year, and health care costs of patients with chronic diseases account for more than 75 percent of the nation's medical care costs.[8] According to Partnership for Prevention, more than 95 percent of US health care expenditures are committed to diseases after they become manifest.[9]

Case In Point: Obesity

According to the Centers for Disease Control and Prevention (CDC), nearly two out of every three adults, 64.5 percent, are overweight and 30.9 percent of adults are obese.[10] Even more alarming is the rapid expansion of the American girth; the percentage of Americans classified as obese doubled between 1980 and 2000. Not surprisingly, research shows that as a person's body mass increases, health care utilization and costs also increase.[11]

Because employers are the primary vehicle providing health insurance, obesity translates into hefty expenditures for employers.[12] On average, health care costs for obese workers are 36 percent higher than those for normal weight workers.[13] Medication costs for obese workers are 77 percent higher. Furthermore, the indirect costs of obesity include decreased productivity and increased absenteeism. In the aggregate, obesity is associated with 39 million lost workdays, 239 million restricted activity days, 90 million bed days, and 63 million doctor's visits.[14] As some employers around the country can attest,

carefully designed wellness programs can meaningfully decrease obesity-related health care expenditures.

WELLNESS PROGRAMS: A TOOL FOR CURBING HEALTH CARE COSTS

Although the popularity of wellness programs has recently jumped in response to health care costs, wellness programs are not a new creation. Employers have been using such programs since the 1970s. Their implementation stemmed from a desire to improve employee health, increase productivity and morale, decrease absenteeism, and reduce health care expenditures related to chronic diseases and disorders.

Wellness programs are now formally being pushed by the federal government. Secretary of Health and Human Services (HHS) Tommy G. Thompson has been actively touting wellness programs under two new initiatives, Steps to a HealthierUS and Healthy People 2010. These programs are designed to bring about better business and longer lives. Secretary Thompson declares that he has "made prevention a priority" within HHS and is "leveraging the expertise and resources of each agency within the department." After commenting that worksites "offer important opportunities to strengthen prevention," he admonishes Americans to "learn more about the successful worksite health promotion and disease prevention programs being offered by worksites now so that we can build upon those successful efforts."[15]

Judging by the numbers, it appears that wellness programs have finally caught on in the workplace. On a national level, 80 percent of worksites with 50 or more employees and almost all employers with over 750 employees offer some form of a wellness program.[16] The focus and comprehensiveness of these programs vary greatly across companies. Some employers focus on a single risk factor, such as smoking, or a particular disease, such as cardiovascular disease. Other companies offer a wide range of health promotion and disease prevention programs.

Squarely in the crosshairs are obesity, diabetes, cardiovascular disease, asthma, and tobacco-related conditions. As part of the move toward consumerism in employer-sponsored health plans, some employers are now offering employees direct financial incentives to encourage healthy behaviors. A commonly used incentive is offering reduced health insurance premiums, co-pays, or deductibles in exchange for taking a health risk assessment, participating in disease management programs, following preventive health guidelines, setting personal health goals, or engaging in other healthy behaviors.

Whatever their composition or design, statistical evidence suggests that wellness programs can have a major impact on health care costs—and thus corporate bottom lines. One recent review of nine large employers (including General Mills, Pacific Bell, Chevron, and

General Motors) found that their wellness programs generated returns on investment ranging from $1.49 to $4.91 for each dollar spent, with the median being $3.14.[17] Some clearly remain skeptical, but mounting empirical data indicates that wellness programs generally are working. Representative examples of successful wellness programs include the following:

- Johnson & Johnson's Health and Wellness Program has produced annual savings of $224.66 per employee.

- Northeast Utilities WellAware Program reduced lifestyle and behavioral claims by $1,400,000 in the first 2 years.

- Motorola's wellness program saved the company $3.93 for each $1 invested.

- Caterpillar's Healthy Balance program is projected to result in long-term savings of $700 million by 2015.

Common Components of Wellness Programs

According to a 2001 Hewitt survey of 945 major U.S. companies, 93 percent of the employers offered some type of wellness program.[18] Among the most popular programs were…

- Health-Related Education or Training: 72 percent (*e.g.,* seminars, workshops, or counseling regarding lifestyle behavior contributing to chronic illness).

- Financial Incentives or Disincentives: 42 percent (*e.g.,* incentives: monetary awards for employee participation in health risk assessments or screenings; disincentives: charging employees higher medical premiums if they smoke).

- Disease Management Programs: 76 percent of employers offer disease management programs to their employees and 84 percent offer the programs through self-insured and/or fully insured health plans (proactively identifying employees who are at a high risk for targeted medical conditions).

- Health Risk Assessments or HRAs: 28 percent (questionnaires or tests that are used to analyze employee health history and promote early detection of preventable conditions).

- Health Screenings: 75 percent (*e.g.,* blood pressure and cholesterol readings and mammograms).

• Special Programs for Disease and Medical Management: 79 percent (*e.g.,* flu shots or prenatal care).

• Other Health Promotion Activities: smoke-free workplace (57 percent); health fairs (42 percent); on-site fitness facilities (35 percent); and health club discounts (23 percent).

In short, wellness programs come in all shapes and sizes. They are as different as the employers that sponsor them. Employers should custom-tailor their programs to meet the specific needs of their unique workforce. In doing so, however, they should be aware of various legal and compliance issues that may arise with their wellness programs. This article is not intended to provide exhaustive guidance on all legal issues involving wellness programs. Rather, it highlights the most common issues plan sponsors are likely to face.

LEGAL IMPLICATIONS OF WELLNESS PROGRAMS

Historically, many employers (and employee benefits practitioners) have not considered their wellness programs to be "health plans" from a legal compliance standpoint. Moreover, government regulators rarely have had wellness programs on their radar screens. Considering the rapidly increasing prevalence and sophistication of wellness programs, however, this lack of regulatory attention may be about to change. Implementing a wellness program clearly can have legal implications for employers—and in some instances their employees too. In particular, wellness programs raise issues under the Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act (ADA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), and health saving account (HSA) regulations. These issues encompass potential employer reporting and disclosure requirements, employee medical privacy, nondiscrimination in health plan eligibility and benefits, COBRA continuation coverage, and the ability of individuals to contribute to HSAs.

ERISA

Whether the particular wellness program of an employer is subject to ERISA can have significant consequences for the employer. Among other responsibilities, ERISA's slate of reporting and disclosure requirements apply to ERISA-covered plans, as do the gamut of fiduciary duties. In addition, an employer that knows it has an ERISA-covered plan can proactively make plan design decisions to help protect itself. This includes actions like reserving discretionary authority to interpret the plan and limiting the window of time in which lawsuits can be

filed. It is thus critical to determine when ERISA applies. Failure to recognize that a wellness program (or any other plan) is subject to ERISA can lead to significant government-assessed penalties, as well as costly litigation by employees seeking benefits.

Wellness programs may or may not be subject to ERISA, depending on the type of benefits they offer. ERISA covers "employee welfare benefit plans," which are defined as: (1) a plan, fund, or program; (2) that is established or maintained by an employer; (3) for providing certain enumerated benefits (including "medical care"); (4) to participants and their beneficiaries.[19] There is scant guidance available on when a wellness program would actually satisfy these requirements.

In a Department of Labor (DOL) Information Letter regarding whether an employer's wellness program, which included medical examination benefits, was subject to ERISA, the DOL stated:

> There is no prerequisite condition of a formal, written plan for coverage under ERISA [S]ection 3(1), See *Donovan v. Dillingham,* 688 F.2d 1367, 3 EBC 2122 (11th Cir. 1982). Neither does the scope or frequency of the plan benefits affect the status of the program in our determination of what activities constitute the establishment of an employee welfare benefit plan. The [wellness programs you maintain for employees] may constitute "employee welfare benefit plans" if [they] provide benefits described in ERISA [Section] 3(1).[20]

Certain wellness programs go beyond simply promoting healthy lifestyles to the point of providing ongoing health care benefits. While a regulatory exemption is available under ERISA for on-site health facilities, wellness programs typically do not qualify for this exemption because they offer benefits beyond treatment for minor injuries or illnesses, or the rendering of first aid for workplace accidents.[21] Moreover, a typical wellness program likely does not qualify as a "facility" as contemplated by the exemption.

As noted, the DOL has specifically indicated that wellness programs providing "medical care" may be considered employee welfare benefit plans subject to ERISA. "Medical care" includes amounts paid for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body."[22] This expansive definition arguably could apply to nearly all wellness programs. Thus, a literal reading of ERISA indicates that essentially any wellness benefit an employer provides as part of an ongoing program (*e.g.,* annual flu shots, mammograms, cholesterol testing, or physical exams) could be deemed an employee welfare benefit plan subject to ERISA. This would implicate ERISA's broad array of requirements—including claims procedures, summary plan descriptions, and Form 5500 requirements. To date, the DOL has not aggressively pursued this position.

In sum, wellness programs may or may not be subject to ERISA, depending on whether they provide "medical care." Employers should seek legal assistance to determine their obligations under ERISA. The DOL may step up ERISA enforcement in the wellness program arena as wellness programs become an increasingly vital and integrated part of employer health plans.

HIPAA

Wellness programs raise potential issues under both the HIPAA privacy rules (Privacy Rules) and the HIPAA nondiscrimination rules (Nondiscrimination Rules).

HIPAA Privacy Rules

Several questions arise concerning how the HIPAA Privacy Rules impact wellness programs. For instance, are wellness programs even subject to the Privacy Rules at all? If so, to what extent can protected health information (PHI) from a wellness program be shared to evaluate its impact on an employer's overall health care and disability costs? Does an employer need a business associate agreement with wellness program vendors?

In considering these questions, employees should bear in mind one of the cardinal principles of the Privacy Rules: employers may not use PHI from the health plan to make employment-related decisions (*e.g.,* hiring, firing, or promoting). PHI generally may be used only for treatment, payment, or health care operations of the health plan. Employers must be cautious that health information from its wellness program (which may be a "health plan" subject to the Privacy Rules) is not impermissibly shared with the employer.

The Privacy Rules apply only to certain health care providers, health care clearinghouses, and health plans. The question here is whether a wellness program is a "health plan." As noted above, employers typically have not treated wellness programs as health plans for ERISA purposes (*i.e.,* plan documents, SPDs, and Form 5500s). However, the definition of "health plan" under the Privacy Rules is broader than the ERISA definition.

The Privacy Rules identify seventeen different arrangements that qualify as "health plans." Two of these arrangements arguably could encompass many wellness programs. The first is basically the ERISA definition (described above). The second is a catch-all provision that includes "any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care."[23]

Is a wellness program an ERISA health plan? While most employers have not treated their wellness programs as ERISA-covered health plans in the past, the HIPAA Privacy Rules may now force employers

to reconsider whether their wellness programs are in fact ERISA plans. A literal reading of the HIPAA Privacy Rules (and ERISA) would mean that essentially any wellness service an employer provides as part of an ongoing program could be a "health plan" subject to the Privacy Rules.

Although the DOL could point to statutory/regulatory language and argue that many wellness programs are ERISA plans, the enforcement of such position to date (at least based on anecdotal experience) has been minimal. Informal discussions with the Office of Civil Rights (OCR)—the agency that enforces the Privacy Rules—indicate that OCR initially will take a similar, "low priority" stance toward wellness programs. With the rapidly increasing number and variety of wellness programs, however, federal regulators may decide that these programs represent an area of potential risk to the privacy of health information and take a more aggressive enforcement posture.

Is a wellness program "any other . . . plan"? Regardless of how ERISA defines a "health plan," the HIPAA Privacy Rules also contain a catch-all definition of health plan: "any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care." This could be interpreted to include almost any type of wellness program since the definition of medical care is so broad (*e.g.,* it includes disease prevention). Using this catch-all clause, OCR could consider wellness programs to be "health plans" covered under the Privacy Rules irrespective of whether they constitute ERISA health plans.

We understand that the HHS, the federal agency tasked with drafting the Privacy Rules, received numerous comments from employers and disease management/wellness program vendors during the 1999-2000 comment period. HHS apparently held several meetings with these groups to discuss how wellness programs should be regulated by the Privacy Rules. Some of the groups wanted HHS to completely exclude wellness programs from the definition of "covered entity" so that they could continue to use PHI freely (as was done for disability and workers' compensation programs, for instance). Others felt that wellness programs should be regulated but wanted a special rule to allow use of PHI without authorization for certain specified purposes.

Although HHS apparently was receptive to this latter approach, the groups could never agree on a common definition of disease management and wellness programs, or the threshold requirements for a special rule. Hence, HHS did not make any changes to the proposed regulation to clarify how wellness programs should be treated. To date, OCR has not addressed this issue from an enforcement standpoint either. While OCR has informally stated that it initially will not treat traditional wellness programs as "health plans," employers should remember that OCR may change its enforcement position at any time.

Since wellness programs technically may be "health plans" and subject to the Privacy Rules, employers should consider giving wellness programs the same protections as their other health plans—meaning full HIPAA Privacy compliance. The wellness program could be addressed in an employer's health plan privacy policies and procedures, privacy notice, etc.

Treating the wellness program as a health plan subject to the Privacy Rules may allow the exchange of PHI between the wellness program vendor and the employer's other health plans (insurers and HMOs). This is possible because the wellness program can be included in the employer's organized health care arrangement (OHCA). Using this model should allow health plans to analyze the success of the wellness programs and then share results with the employer in the form of aggregate data.[24] Employers should not receive individually identifiable health information from the wellness program. In structuring these arrangements, it may be necessary for the health plan to have a business associate agreement with a wellness program vendor or related parties. Employers should be reminded that health information from a wellness program potentially is PHI and should be safeguarded accordingly.

HIPAA Nondiscrimination Rules

HIPAA also prohibits employers from discriminating among similarly situated employees based on their health status. Employers cannot deny enrollment eligibility or charge individuals different premiums or impose different costs (such as deductibles or co-pays) based on a health factor. "Health factors" include health status, medical condition (both physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.[25]

HIPAA was not designed to discourage employers from promoting employee health and well-being through wellness programs. Under proposed regulations, special rules allow wellness programs to provide rewards based on a health factor.[26] Such programs must satisfy these so-called bona fide wellness program (BFWP) requirements. Importantly, plans that do not provide rewards based on a health factor are not required to comply with the BFWP requirements.

Examples of programs that do not provide rewards based on a health factor include: (1) incentives to participate in a health fair or screening, regardless of outcome; (2) reimbursement for smoking cessation or weight loss programs, regardless of outcome; and (3) reimbursement for health club memberships, regardless of any health factors relating to the employee.[27]

If a wellness program provides a reward based on the satisfaction of a standard related to a health factor, the program must satisfy the four BFWP requirements described below. (Note that these BFWP rules are proposed regulations; final regulations due out soon may

revise these requirements.) Programs satisfying these requirements are deemed to comply with HIPAA's nondiscrimination rules governing wellness programs. The four BFWP requirements are as follows:

1. The BFWP must limit the reward to 10 percent, 15 percent, or 20 percent of the cost of coverage. The financial reward, when combined with any other rewards for BFWPs under that plan, cannot exceed one of the alternative limits of 10 percent, 15 percent, or 20 percent of the unsubsidized cost of employee-only coverage, even if the employee actually elects family coverage.[28] When determining the percentage, the full cost of employee-only coverage, including both the employer and the employee-paid portions, should be used.

2. THE BFWP must be designed to promote health or prevent disease. The program must be reasonably designed to promote health or prevent disease. A plan will not meet this standard if it does not permit participants to re-qualify for the program at least once annually.

3. The BFWP must be available to all similarly-situated participants. The program must be universally available to all similarly-situated participants. Reasonable alternatives must be provided for participants who cannot meet the health standards due to a medical condition or for whom achievement of the standard is medically inadvisable.29 This means that the wellness plan must provide for individually-tailored adjustments.30 This could entail an alternative means that does not involve a health standard (such as having the employee attend a wellness class) that anyone who cannot meet the health standard must satisfy.

4. The BFWP must provide a notice that individual accommodations are available. All materials that describe the program must explain that individual accommodations are available. The following language is deemed to satisfy this requirement:

   > If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.

Examples of BFWPs that fulfill the "available to all participants" requirement include:

- **Cholesterol Reduction Programs.** A bonus or discount for cholesterol levels below 200, as long as the program allows

those medically unable to comply to work with the employer to develop an alternative.

• **Body Fat Index Programs.** A bonus or discount for specified body mass index, as long as it allows for alternative qualification such as walking 20 minutes three times a day, and it permits individual accommodations for individuals for whom the walking alternative is unreasonably difficult due to a medical condition or is medically inadvisable.

• **Stop-Smoking Programs.** A health insurance premium discount for employees who do not use tobacco products that permits individuals for whom quitting smoking is unreasonably difficult due to a medical condition (such as addiction to nicotine) to receive the discount by enrolling and continuing to participate in a smoking cessation program, regardless of whether the individual actually quits smoking.

For many workplace wellness programs the BFWP rules simply will not apply. Again, the key question is whether the reward offered to employees is contingent on satisfying a standard related to a health factor. If the answer is yes, the program must satisfy the BFWP rules. If the answer is no, the program passes muster under HIPAA nondiscrimination without needing to comply with the BFWP rules.

Providing a reward to encourage employees to fill out a health risk assessment, comply with preventive care guidelines, enroll in disease management, or set an annual personal health goal, regardless of the outcome of such wellness activities, generally does not involve satisfying a standard related to a health factor. Thus, such programs often are not required to comply with HIPAA's BFWP rules. Because wellness programs are structured differently from company to company, however, it is important that employers carefully evaluate with their legal counsel the HIPAA nondiscrimination implications of their wellness program.

One question that employers are increasingly asking is whether mandatory health risk assessments are permissible under the HIPAA Nondiscrimination Rules. The DOL, HHS, and the Internal Revenue Service (IRS) have joint jurisdiction over the HIPAA Nondiscrimination Rules. These agencies released Q&A guidance regarding the rules. One of the Q&As indicates that requiring employees to fill out a health assessment is permissible in certain circumstances.

> Q: "My group health plan requires me to complete a detailed health history questionnaire and subtracts 'Health Points' for prior or current health conditions. In order to enroll in the plan, an individual must score 70 out of 100 points. I scored only 50 points and was denied eligibility in the plan. Is this permissible?"

> A: "No. The HIPAA nondiscrimination rules do not automatically prohibit health care questionnaires. It depends on how the information that is obtained is used. In this case, the plan requires individuals to score a certain number of 'Health Points' that are related to prior or current medical conditions in order to enroll in the plan, which is impermissible discrimination in rules for eligibility based on a health factor."

The implication of this Q&A is that employers may condition enrollment in a health plan (or the provision of a discount) on an employee's filling out a health risk assessment, so long as (1) eligibility to participate in the plan is not based on the outcome of the assessment; and (2) the premiums the employee pays also are not based on the outcome.

Employers may thus require their employees to fill out a health risk assessment in order to obtain coverage or receive reduced health care costs so long as the outcome of such assessment does not impact employees' eligibility to participate or the amount they pay for coverage.

ADA

Employers subject to the ADA must ensure that implementation and operation of their wellness programs do not run afoul of the ADA.[31] Several key issues arise in terms of ADA compliance. First, wellness programs are increasingly using health risk assessments. Because the ADA limits employers' ability to make "disability-related inquiries," some of the questions posed in the health risk assessment may violate the ADA.

Second, if the questionnaire does contain disability-related inquiries, does the wellness program qualify for the "voluntary" wellness program exception under the ADA? This question is particularly interesting when the employer either requires employees to fill out the health risk assessment in order to receive health coverage—or offers direct financial incentives to do so. Finally, if the rewards under the wellness program are so large as to be considered coercive (thus making the wellness program no longer voluntary) does the health risk assessment qualify for the "job related and consistent with medical necessity" exception? Each of the issues is discussed below.

Does the wellness program's health risk assessment contain questions that are "disability-related inquiries"? In many cases the answer is yes. If so, the employer potentially has an ADA violation unless it qualifies for one of the exceptions.

While these questionnaires vary greatly, some assessments clearly contain disability-related inquiries. EEOC Enforcement Guidance points out that Congress "was particularly concerned about questions that allowed employers to learn which employees have disabilities

that are not apparent from observation.[32] Employers need to identify the questions that constitute "disability-related inquiries" in their questionnaires. EEOC states in its Enforcement Guidance that "disability-related inquiries" include the following:[33]

> . . . asking an employee whether s/he has (or ever had) a disability or how s/he became disabled or inquiring about the nature or severity of an employee's disability;
>
> asking an employee to provide medical documentation regarding his/her disability;
>
> asking an employee's co-worker, family member, doctor, or another person about an employee's disability;
>
> asking about an employee's genetic information;
>
> asking about an employee's prior workers' compensation history;
>
> asking an employee whether s/he currently is taking any prescription drugs or medications, whether s/he has taken any such drugs or medications in the past, or monitoring an employee's taking of such drugs or medications; and,
>
> asking an employee a broad question about his/her impairments that is likely to elicit information about a disability (*e.g.,* What impairments do you have?).

EEOC further clarifies that "questions that are not likely to elicit information about a disability are not disability-related inquiries and, therefore, are not prohibited under the ADA."[34] These types of permitted questions include the following:

> . . . asking generally about an employee's well being (*e.g.,* How are you?), asking an employee who looks tired or ill if s/he is feeling okay, asking an employee who is sneezing or coughing whether s/he has a cold or allergies, or asking how an employee is doing following the death of a loved one or the end of a marriage/relationship;
>
> asking an employee about nondisability-related impairments (*e.g.,* how did you break your leg?)
>
> asking an employee whether s/he can perform job functions;
>
> asking an employee whether s/he has been drinking;

> asking an employee about his/her current illegal use of drugs;
>
> asking a pregnant employee how she is feeling or when her baby is due; and,
>
> asking an employee to provide the name and telephone number of a person to contact in case of a medical emergency.

Many health risk assessments ask a multitude of questions involving detailed personal health information, physical exercise and fitness, emotional health, nutrition, diet, stress, health/lifestyle changes, health care received, and family medical history. Based on the above EEOC guidelines, some of these questions clearly could be deemed "disability-related inquiries." Others almost certainly are not (*e.g.,* "How do you feel in your daily life?").

Problematic questions that constitute "disability-related inquiries" would specifically include those that ask employees about weight, body frame size, blood pressure, cholesterol, diabetes, cancer, heart disease, medical treatment received, personal and family medical history,[35] and whether they take medication[36] for high blood pressure. In other words, a significant percentage of common questions could constitute disability-related inquiries.

It is possible that health risk assessments could be narrowed down so they do not ask any questions that constitute disability-related inquiries. This would be the most straightforward way to comply with the ADA. Deleting key questions, however, may significantly impair the effectiveness of both the health risk assessment and the underlying wellness program. Accordingly, revising the health risk questionnaire may not be a viable option for many employers. It is thus necessary to look to the ADA's exception for voluntary wellness programs. Assuming the program truly is voluntary, disability-related inquiries are permitted.

Is a wellness program "voluntary" when employees cannot receive health coverage, or cannot receive reduced health insurance premiums or lower co-pays/deductibles, unless they fill out a health risk assessment? EEOC guidelines indicate that employers may make "disability-related inquiries" as part of a voluntary wellness program.[37]

EEOC states that the ADA "allows employers to conduct voluntary medical examinations and activities, including voluntary medical histories, which are part of an employee health program without having to show that they are job-related and consistent with business necessity, as long as any medical records acquired as part of the wellness program are kept confidential and separate from personnel records. These programs often include blood pressure screening, cholesterol testing, glaucoma testing, and cancer detection screening. Employees may be asked disability-

related questions and may be given medical examinations pursuant to such voluntary wellness programs."[38]

As described above, the HIPAA Privacy Rules likely require most wellness programs to safeguard the health information obtained from a health risk assessment. So the key question is whether an employer's wellness program is truly "voluntary" when employees are required to fill out the health risk assessment in order to obtain health coverage or receive reduced health plan premiums or costs.

We could identify no case law on what constitutes a "voluntary" wellness program, and the EEOC has provided only minimal guidance on this topic. EEOC considers a wellness program to be "voluntary" if an employer "neither requires participation nor penalizes employers who do not participate."[39]

Withholding participation or reduced costs certainly could be viewed as a penalty. Strong arguments, however, can be made that even these wellness programs are in fact voluntary, and that employees would not be harmed in any way by filling out a health risk assessment. First, employees generally are not required to fill out the assessment. Participation in wellness programs is completely optional. If employees want health coverage or reduced premiums and co-pays/deductibles, they have the option to fill out the wellness program questionnaire. If they do not want to fill it out, they are not obligated to do so.

Second, employers would never learn about the particular health conditions of their employees by virtue of the health questionnaire. The information would be carefully safeguarded by the wellness program, and the HIPAA Privacy Rules prevent the wellness program from sharing this with the employer[40]—and from making employment decisions based on the information even if it did get hold of it. A wellness program may provide data back to employers, but this should be limited to aggregate data that contains no individually identifiable health information. Hence, employers could not discriminate against individual employees based on this information.

Third, even if employers could obtain this health information, the HIPAA Nondiscrimination Rules prevent employers from using it to limit health plan eligibility or charge more for health coverage. In fact, HIPAA's Nondiscrimination Rules permit mandatory health risk assessments so long as: (1) eligibility to participate in the health plan is not based on the outcome of the assessment, and (2) the premiums the employee pays also are not based on the outcome.[41] If the EEOC were to prohibit financial incentives for completing health risk assessments, the EEOC would largely vitiate this HIPAA rule because an employer that complies with the HIPAA rule would inherently violate the ADA.

Understanding the history and purpose behind the ADA's voluntary wellness program exception may shed light on when EEOC would view wellness programs as truly "voluntary." EEOC Enforcement

Guidance cites the ADA's legislative history: "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 preventing occupational advancement, these activities would fall within the purview of accepted activities."[42] The Congressional concern here seems to be that health information might improperly be used for denying health coverage (or charging more for the coverage), or used for making employment decisions. These are precisely the same concerns already addressed by the HIPAA Nondiscrimination and Privacy Rules.

The HIPAA Nondiscrimination Rules are designed, in part, to prevent employers from discriminating against employees, in regard to their health coverage, based on their health condition. An argument can be made that both HIPAA's prohibitions (Nondiscrimination and Privacy) and the ADA's prohibition on medical inquiries seek to prevent the same type of abuses. Because the federal government has already stated that employers can use mandatory health risk assessments in the HIPAA Nondiscrimination context, then arguably the same logic should be applied under the ADA. If the EEOC were to agree that the protections HIPAA introduced (subsequent to the ADA) to protect health information from being abused for purposes of health insurance and job protection, the EEOC may be comfortable allowing mandatory health questionnaires or those tied to financial incentives.

In spite of the above arguments, EEOC may decide that denying employees access to health coverage or reduced insurance costs is akin to a penalty. ("If you don't fill out the health risk evaluation, we're going to penalize you by making you pay more for your health coverage—or by not letting you enroll at all.") This conclusion would mean that participation in the wellness program is not truly "voluntary." The need for affordable health insurance has become increasingly important—both to employees and as a political and regulatory issue. EEOC may feel that conditioning health care costs on responding to a medical inquiry crosses the line from voluntary to coercive, thus violating the ADA. From a logic standpoint, employers thus should keep in mind that the smaller the financial incentive is under the wellness program, the less it looks like a "penalty" for those who choose not to participate. Guidance from the EEOC on these issues would be welcome.

If the wellness program is not "voluntary," is the health risk assessment permitted as an inquiry that is "job-related and consistent with business necessity"? No, probably not. The ADA generally requires employers to demonstrate a particular need for medical information that is specific to the individual employee. Per EEOC guidelines, before an employer can make a "disability-related inquiry" it must show that: (1) an employee's ability to perform essential job functions is impaired by a medical condition; or (2) an employee poses a direct threat due to a medical condition. Most employers will be unable to

demonstrate this for most of its workforce. Thus, requiring health risk assessments from all employees in order to receive health coverage or financial incentives likely will not be considered "job-related and consistent with business necessity."

COBRA

Employer-provided wellness programs that offer an ongoing program of health care services such as flu shots, cholesterol screenings, and physicial examinations may be providing "medical care." The wellness program may thus constitute a "group health plan" for purposes of COBRA. Employers generally are subject to COBRA for qualifying events occuring in a given year unless they had fewer than 20 employees employed on a typical business day during the previous calendar year.[43] Employers that are subject to COBRA need to carefully evaluate whether their wellness programs are "group health plans" subject to COBRA. Failure to properly comply with COBRA can result in significant civil penalties and liability for medical expenses. As a practical matter, we have not yet seen COBRA implicated for wellness programs in the real world. The statutory authority for it appears to exist, however.

HSAs

In response to the escalating health care costs described above, employers are honing in on consumer driven health plans (CDHPs) with deep interest. Health savings accounts or HSAs are the latest player to emerge on the CDHP scene. CDHPs aim to encourage individuals to more actively participate in their health care decisions and to become more financially vested in such choices. CDHPs often entail high deductible health insurance coupled with a personal savings account that allows employees to pay medical care expenditures on a tax-favored basis. The theory is that individual health care consumers will treat the personal account as their own money and, consequently, spend it more prudently.

HSAs are similar to tax-favored, individual retirement accounts (IRAs). Employees covered by high deductible health plans (HDHPs) can establish an HSA to pay for medical expenses for themselves, their spouses, and their tax dependents. One of the key limitations is that individuals are only eligible to contribute to an HSA if they are covered under an HDHP. Individuals with HDHP coverage can contribute to their HSAs on a pre-tax basis under a cafeteria plan or contribute after-tax dollars and then take an above-the-line deduction on their tax return. Employers can also make tax deductible contributions to HSAs. The earnings in HSAs, as well as subsequent distributions for qualified medical expenditures, are not taxed.

Individuals are not eligible to contribute to an HSA if they have health coverage other than the HDHP. Questions had arisen about whether participation in a workplace wellness program would constitute other health coverage that would disqualify an individual from making HSA contributions. In IRS Notice 2004-50, the IRS clarified that individuals would not be prevented from contributing to an HSA simply because of their participation in a wellness program, disease management program, or employee assistance program (EAP), so long as they do not provide significant benefits in the nature of medical care and treatment (excluding benefits for preventive care services identified in Notice 2004-23).

This IRS guidance is very favorable for employers and their wellness programs. Employers still need to ensure that their wellness programs are not a subterfuge for offering medical care, thus inadvertently disqualifying employees from being eligible to contribute to an HSA.

The IRS position that participating in a typical wellness program does not disqualify an employee from contributing to an HSA may have implications that extend to other important federal laws regulating employee benefit plans. In the HSA guidance, the IRS essentially states that a traditional wellness program (or employee assistance program (EAP) or disease management program) is not a "health plan" for HSA purposes.[44] Is it a "health plan" for other purposes, however, such as under ERISA, COBRA, and HIPAA?

For instance, the DOL has previously ruled that certain EAPs are essentially health plans subject to ERISA because they provide "medical care" (DOL Opinion 88-04A). This puzzles many employers and benefits practitioners who do not observe federal regulators actually treating EAPs as "health plans." Now that the IRS has formally established that many traditional EAPs, wellness programs, and disease management programs are not "health plans" for HSA purposes, guidance is certainly welcome from the DOL and other agencies about whether such programs are indeed health plans under ERISA, COBRA, and HIPAA. Trying to reconcile the new IRS guidance with prior DOL pronouncements is challenging. Absent some additional guidance, employers will have a difficult time trying to read the tea leaves.

PROPOSED LEGISLATION FAVORING WELLNESS PROGRAMS

Corporate America is not alone in taking note of wellness programs. Congress is now considering ways to help employers promote wellness programs. US Senator Peter Fitzgerald (R-Ill.) introduced the Healthy Lifestyles Act on May 10, 2004. This legislation calls for the Director of the CDC and the Secretary of Labor to award grants to businesses for: (1) the development of activity friendly worksites that encourage employee participation in physical activity (which may include providing facilities for physical activity, accessible and attractive stairwells,

walking trails, and supportive management practices); (2) the development of worksite wellness programs that improve physical activity by increasing the knowledge, attitudes, skills, and behaviors of employees; and (3) the development of employee incentive programs to increase participation in worksite health promotion programs that increase physical activity (such as health club memberships, small cash bonuses, and time off).[45]

On June 18, 2004, US Senator Tom Harkin (D-Iowa), unveiled the HeLP (Healthy Lifestyles and Prevention) America Act, which is comprehensive, wellness-based legislation focusing on schools, workplaces, and communities. Title II of the HeLP America Act seeks to assist businesses and communities in promoting healthy lifestyles. The proposal offers tax credits for 50 percent of the costs incurred by companies for offering qualified wellness programs.

Under this proposal, "qualified wellness programs" contain the following three components: (1) health and awareness (this section includes health education and health screening programs); (2) behavioral change (including counseling, seminars, on-line programs or self-help materials related to smoking, obesity, stress management, physical fitness, nutrition, substance abuse, or depression); and (3) supportive environment (this section focuses on on-site policies that promote wellness, participation incentives and employee input). Small employers (200 or fewer employees) must offer programs containing at least two of the three wellness program components. Businesses with more than 200 employees must implement all three components.[46] The legislation also calls for the CDC to analyze employer-based wellness programs and determine best practices, the health effects of wellness programs, and the return on investment generated by employers.

These types of legislation seem to signal a new era of broad based support for wellness programs. It will not be surprising if this legislation, or similar future legislation, is ultimately passed. The government, the corporate sector, and the health care community appear to be working hand in hand to foster workplace wellness programs.

CREATING A SUCCESSFUL, CUSTOM-TAILORED WELLNESS PROGRAM

Despite the different types of wellness programs available, one common thread runs through all successful programs: they are well-designed to meet the employer's unique needs and have strong companywide backing. According to the Wellness Councils of America (WELCOA), a nationally recognized, nonprofit membership organization and information center, there are seven fundamental steps employers should take in crafting and implementing effective wellness programs.[47]

1. Management Support

The first step is to capture senior-level support for the wellness initiative. For a wellness plan to be successful, the organization as a whole must be committed to it. In addition, senior level support is vital to securing the financial resources necessary to deliver effective programming. Senior executives can also assist in integrating the wellness program by linking wellness objectives to business goals.

2. Wellness Program Implementation Team

The second step is to create a cohesive, multidisciplinary wellness team to oversee the company's wellness efforts. A wellness team adds credibility and visibility to a company's wellness initiative. It also provides continuity when personnel changes occur. The wellness team should be in charge of setting and monitoring wellness goals. The team should collect data necessary to gage the current wellness status of employees and then set incremental goals for achieving the company's ultimate wellness goals. These goals may include containing health care costs, decreasing absenteeism, attracting new employees, motivating employees to exercise and make wise nutritional decisions, and increasing overall employee satisfaction and retention. Whatever the employer's ultimate goals, the incremental goals should be measurable in terms of outcomes and cover a specific time period.

3. Data Collection

The third step in creating a successful wellness program is collecting and analyzing the right data. Although a thorough needs assessment can be relatively expensive, it is critical to the overall effectiveness of a wellness plan. The wellness team should gather two specific types of information. The first type of data focuses on what the company's business needs are. What is it that the company wants to accomplish? There are numerous sources for the data necessary to address this question:

- Medical Claims: By reviewing medical claims, employers can determine the costs of employee health care and claim trends (*e.g.,* increasing injuries).

- Absenteeism: Absenteeism levels are strong indicators of overall employee health and morale.

- Disability: Disabled employees are generally very costly. By reviewing the causes of disabilities (*e.g.,* heavy lifting, excess stress due to heavy traveling), employers can more effectively take measures to prevent disabilities in the future.

• Facility Assessment: By examining the health and safety of the workplace, including such areas as ergonomics, eating facilities, security, crowding, fire safety, slippery floors and inadequate lighting, employers can craft preventive strategies to reduce injury and discomfort.

• Health Risk Assessments or HRAs: HRAs can be a valuable source of information regarding employee wellness levels. HRAs can be custom drafted by individual companies or purchased from vendors, who score answers and provide confidential health reports to employees and aggregate information to the employer. HRAs should be filled out by employees each year to alert them to new and existing health risks.

• Screening Data: Screening data, which includes blood pressure, height/weight ratios and cholesterol level testing, can often be done at health fairs and is a useful supplement to data gathered from HRAs.

• Culture Audit: A culture audit, which often consists of a questionnaire regarding employee perceptions about workplace culture and whether or not the culture promotes health. For example, are people who take flex time perceived as being penalized for doing so? Are employees expected to come to work even when they are ill?

The second type of data needed relates to employee interests. What kind of wellness activities will attract and retain the enthusiasm of employees? This information is gathered through questionnaires, focus groups, and individual interviews. Initial and continuing participation levels are two of the most critical elements of successful wellness programs. If employees are not interested in the wellness team's tactics, participation levels will be low and the program will be less effective.

Once adequate employer and employee data have been collected, the wellness team should carefully evaluate the findings. Often the most effective means of communicating the results is through a report to senior management. Any sensitive information in the report should be handled thoughtfully and confidentially. It generally should not be released to shareholders, employees, or the general public.

4. Strategic Implementation Plan

The fourth step in creating a successful wellness program is to draft a detailed, outcome-oriented operating plan that describes how the wellness program will benefit both the company and its employees. Wellness plans that link health objectives to business priorities are

more likely to be effective. Having an operating plan communicates and legitimizes program activities to senior management, provides continuity through personnel changes, increases accountability for the wellness team, and provides a way to measure the overall effectiveness of the program. Operating plans should generally include the following:

- A vision statement
- A list of goals
- Measurable, achievable, and time-specific objectives
- An outline of implementation procedures and a timeline (detailing individual responsibilities, accountability measures, and a timetable for roll out)
- A description of marketing and communication techniques that will be used (*e.g.,* newsletters, intranet, videos, and Web sites)
- An itemized budget
- An evaluation plan

5. Targeted Intervention

Choosing appropriate intervention is the fifth step in creating a successful wellness program. Intervention methods include: printed health information, messages from senior management, group education, self-study programs, computer-based programs, personal coaching, support groups, and corporate policies and incentives. The precise intervention methods a company employs to implement its wellness plan should be based on several factors:

- Wellness plans should be tailored to the demographics and specific risk factors of its unique employee population. By targeting the health factors that cost the most (in terms of medical claims and productivity), employers can maximize the cost-effectiveness of wellness-related expenditures.
- Intervention methods should be consistent with management goals. For example, if an employer is concerned about employee retention, morale and corporate culture, it may decide to utilize a broad range of wellness programming, including fitness activities, child care services and stress management programs. If the

employer is primarily concerned with controlling costs, disease management and self-care programs may be the best place to focus.

• Intervention techniques should be carefully tailored toward employee interests and then promoted vigorously.

• The amount of time and money an employer is willing to dedicate to wellness programming will influence the intervention method employed. If employers have a limited budget, utilizing resources from the local community (*e.g.*, the YMCA), nonprofit organizations, and the government can often provide substantial cost savings.

Appropriate intervention methods should be based on research. There is no shortage of excellent resources to help companies design and implement their own wellness programs.[48]

6. Wellness Promoting Atmosphere

The sixth step to creating a successful wellness program is fostering a supportive environment. The workplace environment has a profound impact on employee health and wellness. Employees who feel cared for and supported generally are more productive and loyal. Employers should thus focus on several specific areas to ensure their worksites promote health and wellness:

• Evaluate how to increase the overall "friendliness" of facilities (*e.g.,* ensure that work areas are comfortable and conform to ergonometric standards, provide healthy vending machine options, create a walking path for employees to use during breaks, eliminate safety hazards).

• Implement proactive policies that foster employee health and well-being (*e.g.,* require seatbelt use in company vehicles, allow for flexible work schedules to enable employees to exercise and attend their children's school events, provide a fitness membership discount, create an absenteeism policy that rewards employees for not using sick days).

• Recognize and reward employee wellness successes (*e.g.,* provide incentives for success, illustrate employee lifestyle improvements in newsletters, bulletin boards, meetings and company events).

• Have management model and support healthy behavior. The benefits of management interaction are numerous.

When employees from different departments and levels of leadership interact in the relaxed environment that wellness programs afford, solidarity and communication are increased companywide.

- Ensure that the wellness initiatives are ongoing.

7. Outcome Evaluation.

The final step in creating a successful wellness program is to continuously and consistently evaluate outcomes. This step is critical for identifying which intervention approaches are most effective and for determining the true costs and benefits of the wellness program. Careful evaluation also provides participants with feedback and generates valuable information about the program. Common targets of evaluation include: participant knowledge and skill, reduced risk factors, participant satisfaction, effects on corporate costs, participation rates, health care claims, length of disability leaves, absenteeism rates and productivity.

CONCLUSION

As health care costs continue their mercurial rise, US businesses, the health care industry, and the government are all looking to employee wellness programs as a bright source of hope and a partial solution to the health care crisis. The gradual nationwide shift toward consumerism and preventive care has created a new environment in which wellness programs can flourish. Because most US health care expenditures go toward treating chronic diseases that are largely preventable, investing in employee wellness programs not only can improve employee health and productivity, but also shore up the corporate bottom line. On average, employers are reaping several dollars in health care savings for each dollar spent on employee wellness programs.

Although still relatively unknown and untested, potential legal issues arise from wellness programs under ERISA, HIPAA, ADA, COBRA, and the HSA rules. These issues include employer reporting and disclosure requirements, employee medical privacy, nondiscrimination in eligibility and benefits, COBRA continuation coverage, and the ability of individuals to contribute to HSAs. Each employer's wellness program should be carefully reviewed to ensure compliance with these laws.

Proposed federal legislation would further energize wellness programs by offering employer tax credits and other monetary

incentives. In sum, wellness programs appear to be a key component in reining in health care costs for US businesses. If carefully designed and implemented, they can greatly benefit both companies and their employees.

NOTES

1. *Benefitnews.com Connect*, Employee Benefits News, Feb. 1, 2003.

2. Centers for Medicare and Medicaid Services, Table 1, National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980–2002, available at *http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp*.

3. Centers for Medicare and Medicaid Services, Table 3, National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1990–2013 (2004). The health spending projections were based on the 2002 version of the National Health Expenditures (NHE) released in January 2004.

4. Centers for Medicare and Medicaid Services, Table 1, National Health Expenditures and Selected Economic Indicators, Levels and Average Annual Percent Change: Selected Calendar Years 1990–2013. The health spending projections were based on the 2002 version of the NHE released in January 2004.

5. Susan Duff, "'99 Data Raise Worries: Health Costs Approach Red Line," *Employee Benefits News*, Feb. 1, 1999.

6. Health Care Expectations: Future Strategy and Direction, Hewitt Associates (2004).

7. Morgan O'Rourke and Laura Sullivan, "*Corporate Wellness: A Healthy Return on Employee Investment*," 50 *Risk Management* 34 (Nov. 1, 2003).

8. Available at *www.cdc.gov/nccdphp*.

9. Available at *www.welcoa.com*.

10. National Center for Health Statistics, Health, United States, 2003 (2003). Table 68.

11. K.A. Heithoff, B.J. Cuffel, S. Kennedy, J. Peters, "The association between body mass and health care expenditures." 19 *Clinical Therapy* 4, Jul.–Aug. 1997, 811–820.

12. According to the Department of Health and Human Service (HHS), in 1994 obesity-related health problems cost U.S. businesses $13 billion. "HHS Issues Report Aiming to Spur Health Promotion Efforts By Employers," 11 *Health Care Policy Report,* (BNA) 1209, Sept. 22, 2003.

13. Robert J. Grossman, "Countering a Weight Crisis," 49 *HR Magazine* 3, Mar. 2004.

14. *Id*. *See also* National Institute of Health/National Institute of Diabetes and Kidney Diseases, available at *www.niddk.nih.gov/health/nutrit/pubs/statobes.htm*.

15. 2004 Wellness Councils of America, "Investing in the Future," *Absolute Advantage Magazine*, 2–3.

16. J.E. Riedel, W. Lynch, C. Baase, P. Hymel, and D.W. Peterson, "The effect of dis-

ease prevention and health promotion on workplace productivity: a literature review," 15 *American Journal of Health Promotion* 3, 2001, 167–191.

17. Department of Health and Human Services, Prevention Makes Common "Cents," (Sept 2003) available at *http://www.aspe.hhs.gov/health/prevention*.

18. Employers Turn to Wellness Programs as Health Care Costs Rise (Aug. 5, 2002), available at *http://hr.cch.issues-answers/080502.aspHealth*. Promotion/Managed Health Provided by Major U.S. Employers in 2001.

19. ERISA § 3(1).

20. DOL Information Letter (Nov. 17, 1993).

21. DOL Reg. § 2510.3-1(c).

22. 29 U.S.C. § 1191b(a)(2)(A).

23. 42 C.F.R. 160.103.

24. Under the Privacy Rules, group health plans maintained by the same plan sponsor constitute an OHCA. A group health plan's health insurance issuer or HMO may also participate in the OHCA. 42 C.F.R. 164.501. The advantage of an OHCA is that a covered entity that participates in an OHCA may disclose PHI to other covered entities in the OHCA for any "health care operations" of the OHCA. 42 C.F.R. 164.506(c)(5). Since evaluating health plan performance falls within the definition of "health care operations," this would allow the wellness program (if treated as a health plan) to share PHI with insurers and HMOs and vice versa.

25. 45 C.F.R. § 146.121.

26. These rules are contained in the proposed regulations that govern wellness programs. *See* Prop. Treas. Reg. § 54.9802-1(f); Prop. DOL Reg. § 2590.702(f); 45 C.F.R. 146.121(f). These rules have now been in effect for several years and will remain in effect until final regulations are issued.

27. *See* Preamble, 66 Fed. Reg. 1421, 1422 (Jan. 8, 2001).

28. *See* Prop. Treas. Reg. § 54.9802-1(f)(1)(i); Prop. DOL Reg. § 2590.702(f)(1)(i); 45 CFR 146.121(f)(1)(i). The agencies welcome comment on which percentage is most appropriate. Preamble to Proposed Wellness Regulations, 66 Fed. Reg. 1422 (Jan. 8, 2001).

29. *See* Prop. Treas. Reg. § 54.9802-1(f)(1)(iii); Prop. DOL Reg. § 2590.702(f)(1)(iii); 45 C.F.R. § 146.121(f)(1)(iii).

30. *See* examples at Prop. Treas. Reg. § 54.9802-1(f)(2); Prop. DOL Reg. § 2590. 702(f)(2); 45 C.F.R. § 146.121(f)(2).

31. Persons or entities engaged in an industry affecting commerce who have 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year are generally subject to the ADA. 29 C.F.R. Section 1630.2.

32. *See* Enforcement Guidance, footnote 14 and accompanying text (Congress "concluded that the only way to protect employees with nonvisible disabilities is to prohibit employers from making disability-related inquiries. . . that are not job-related and consistent with business necessity. *See* S. Rep. No. 101-116 at 39-40 (1989); H.R. Rep. No. 101-485, pt. 2, at 75 (1990).")

33. EEOC Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA) (Enforcement Guidance). Available at *http://www.eeoc.gov/docs/guidance-inquiries.html*.

34. Enforcement Guidance, Question 1.

35. Questions about "genetic information" (which are disability-related inquiries) include questions about the occurrence of a disease, medical condition, or disorder in family members of an individual. *See* Enforcement Guidance, fn. 21.

36. EEOC specifically forbids employers from asking their entire workforce about what medications they are taking. "May an employer ask all employees what prescription medications they are taking?" "Generally, no. Asking all employees about their use of prescription medications is not job-related and consistent with business necessity." Enforcement Guidance, Question 8.

37. Enforcement Guidance, Question 22.

38. Enforcement Guidance, Question 22. The footnote to this information adds, "If a program simply promotes a healthier life style but does not ask any disability-related questions or require medical examinations (*e.g.*, a smoking cessation program that is available to anyone who smokes and only asks participants to disclose how much they smoke), it is not subject to the ADA's requirements concerning disability-related inquiries and medical examinations."

39. Enforcement Guidance, Question 22.

40. Participation in a wellness program may result in decreased health insurance premiums for an employee. An employer thus may be able to look at the amount of an employee's payroll deductions and determine that an employee is participating in the wellness program. However, this is permitted under the HIPAA Privacy Rules. Even fully-insured, "hands-off" employers are permitted to access enrollment and disenrollment information, which presumably includes data concerning payroll deductions that fund the health coverage.

41. *See* the HIPAA Nondiscrimination Q&A cited above, which indicates that requiring employees to fill out a health assessment is permissible in certain circumstances ("The HIPAA nondiscrimination rules do not automatically prohibit health care questionnaires. It depends on how the information that is obtained is used.") Under a wellness program, the information from the questionnaire should not used to determine health plan eligibility or cost. Financial incentives under a wellness program should be awarded for filling out the questionnaire rather than based on the health information obtained from the questionnaire.

42. H.R. Rep. No. 101-485, pt. 2, at 75 (1990). Note that the EEOC does *not* say that the health risk assessment cannot be used to limit health insurance eligibility. It says that the "medical records" (*i.e.*, the *results* of the health risk assessment) cannot be used to limit health insurance eligibility. *Gathering* the health information is not what the rules appear to prevent; rather, *using* the health information for *improper purposes* is the harm the rules *seek* to prevent. This is the same issue that arises under the HIPAA Nondiscrimination Rules. As noted above, HIPAA allows mandatory health risk assessments so long as the results of the assessment do not affect an employee's eligibility for or cost of health coverage.

43. Code § 4980B(d)(1).

44. "This wellness program is not a 'health plan' under section 223(c)(1) because

it does not provide significant benefits in the nature of medical care or treatment." Q&A 10, Example 3, Notice 2004-50.

45. Healthy Lifestyles Act of 2004, S. 2399, 108th Cong. § 3990(c) (2004).

46. HeLP America Act of 2004, S. 2558, 108th Cong. Title II, § 45G (2004).

47. Available at *www.welcoa.com*. Practical tips are provided for topics such as (1) collecting data and analysis; (2) creating a well-designed wellness operating plan; and (3) choosing the appropriate wellness interventions.

48. Helpful Web sites regarding wellness programs include: Wellness Council of America, *www.welcoa.com*; Health Enhancement Research Organization (HERO), *www.thehero.org*; Centers for Disease Control and Prevention, *www.cdc.gov*; Healthy People 2010, *www.healthypeople.gov*. Prevention Makes Common "Cents": Report by the U.S. Department of Health and Human Services, *www.aspe.hhs.gov/health/prevention*. Health Finder, available at *www.healthfinder.gov*.

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