

Employer Mandated Wellness Initiatives: The Continuum from Voluntary to Mandatory Plans

2008-2009

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I. Introduction

In February 2007, Michelle Conlin caught the attention of employers with her *Business Week* article, “Get Healthy — Or Else,” describing Scotts Miracle-Gro’s edict that its employees undergo a health risk assessment and, if necessary, work with a health coach, or forego a significant portion of the employer’s contribution to medical insurance.¹ Scotts Miracle-Gro’s program saved the life of at least one corporate executive and led to a lawsuit, still pending in federal court, by an employee whose employment was terminated when he tested positive for nicotine.²

The *Business Week* article was followed by Littler Mendelson’s April 2007 *Littler Report* on Employer Mandated Wellness Initiatives, examining some of the legal challenges posed by wellness programs and offering employers insight into navigating the many federal and state laws that must be considered when designing, developing, and implementing an employee wellness program, and particularly when implementing a mandatory wellness program.

Where are we a year later? As the leading source of medical insurance, employer-sponsored group insurance covers approximately 158 million nonelderly people in the United States.³ Although the cost of healthcare insurance has moderated,⁴ the percentage of employers offering health insurance continues to decline.⁵ And while employees are paying larger dollar amounts for coverage, the share of the premium paid by workers has remained stable.⁶ Employers have moved from indemnity coverage to preferred provider plans to health maintenance organizations.⁷ Threatened by various federal, state and local initiatives to require employers to provide health insurance coverage, and leery of expecting any comprehensive reform, no matter what the outcome of the 2008 election, employers are now examining what can be done to assure a healthier workforce.

II. How Employers Came to Be the Primary Source of Health Insurance Coverage

Only a short 60 years ago, employer-sponsored health benefits simply did not exist. As a result of federal government restrictions on salaries during World War II, employers sought avenues to retain and recruit talented employees by offering employer sponsored health insurance because the federal regulations on salary control did not prohibit such a perk. Shortly thereafter, the employer sponsored health care coverage boom received another stimulus when Congress made clear that employers could include medical insurance expenses as a deductible compensation expense while the value of the coverage was not included in the employee’s taxable income.

Between 1950 and 2000, employer sponsored health insurance became a widespread practice in the United States. Early private health insurance premium rates were set using what were called “community rating” where most groups paid the same average rate for their insurance. Most individuals paid similar premiums regardless of the condition of their health. Thus, the healthy groups bore some of the costs of the less healthy.

The system began to unravel as health care insurers became adept at segmenting health risks by avoiding risky applicants and redlining entire industries and occupations, such as hazardous work and businesses with higher than average claims. Against this backdrop, other forces began to affect the ability of businesses to afford health insurance for their employees. Health care costs began to outpace growth and corporate and personal incomes.

As of 2000, roughly 70 percent of all private employers offered health insurance to at least some of their employees. That situation has changed dramatically in only the last seven years. Particularly for firms with less than 100 employees, a sharp decline has occurred. Among all firms in the United States,

¹ Michelle Conlin, *Get Healthy – Or Else*, BUS. WEEK, Feb. 26, 2007 Conlin, available at http://www.businessweek.com/magazine/coontent/07_09/b4023001.htm.

² *Rodrigues v. The Scotts Company, L.L.C.*, Case No. C.A. 07-10104-GAO (D. Mass 2007).

³ The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America, 2005 Data Update, May 2007*, available at www.kff.org/uninsured/upload/2005dataupdate.pdf.

⁴ The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Survey of Employer-Sponsored Health Benefits, 2007*, available at <http://www.kff.org/insurance/7672.pdf>. Between spring of 2006 and spring 2007, premiums increased an average of 6.1% for employer-sponsored health insurance, a slower rate than the 7.7% increase in 2006. This is the fourth consecutive year with a lower rate of growth than the previous year, and the lowest rate of growth since 1999, when premiums increased 5.3%.

⁵ *Id.* Sixty percent of employers offered health benefits in 2007, down only slightly from the 61% reported in 2006, but lower than the peak of 69% reported in 2000.

⁶ *Id.* In 2007, the average percentage of premium paid by covered workers was 16% for single coverage and 28% for family coverage.

⁷ *Id.* The majority (57%) of covered workers are enrolled in preferred provider organizations. Health maintenance organizations cover 21%, followed by point-of-service plans (13%), high deductible health plans with a savings option (5%), and conventional plans (3%).

the percentage of those offering health benefits since 2000 has dropped from 70 percent to 60 percent in 2007.⁸

And, as fewer and fewer employees have comprehensive medical insurance, those employees have come to rely on public health care. In turn, states and cities, in the face of escalating public health care costs and tightening civic budgets, are looking to employers who do not provide some form of medical care coverage to their employees to underwrite the public expense of providing such care. Massachusetts was the first state to require its residents to secure health insurance, effective July 1, 2007. As part of the legislation, employers are required to either provide certain minimum levels of health insurance coverage to employees or make a “Fair Share Contribution” to the cost of their employees’ health coverage, to a maximum of \$295 a year.⁹ California’s Governor Schwarzenegger has proposed requiring employers with 10 or more employees who choose not to offer health coverage to contribute 4 percent of payroll toward the cost of employees’ health coverage.¹⁰ The City and County of San Francisco requires employers to either spend the equivalent of \$1.17 to \$1.76 an hour per employee (depending on number of employees) on some form of health benefit, or contribute that amount to the Health Access Program established by the City’s Department of Public Health.¹¹

Another emerging trend is mandatory paid sick leave, something that up to now was always at the employer’s discretion. Currently, San Francisco is the only city to require businesses to provide mandatory sick leave, based on each hour of work performed by an employee within the city limits, regardless of where the employee resides or where the employer is located.¹² Washington, D.C.’s mayor recently signed a similar measure, which now awaits Congressional approval. Also pending before Congress is the Healthy Families Act, introduced in March 2007 that would require every employer in the United States with more than 15 employees to provide seven days a year of paid leave.¹³

Finally, health care has become one of the preeminent issues of both the Democratic and Republican presidential campaigns.

At this writing, Senator John McCain is the presumptive Republican candidate, with either Senator Hillary Clinton or Senator Barack Obama the likely Democratic candidate. Senator McCain has proposed reforming the tax code to eliminate the bias toward employer-sponsored health insurance, a proposal that will certainly impact both employers and employees.¹⁴ Both Senators Clinton and Obama have proposed expanding the Federal Employee Health Benefit Program to cover all Americans and requiring employers that do not offer or make a “meaningful” contribution to the cost of quality health coverage for their employees to contribute a percentage of payroll toward the costs of the national plan.¹⁵

III. Improving the Health of the Workforce: The Movement from Reimbursement of Medical Expenses to Prevention and Management of Chronic Disease

Having exhausted options for making group health insurance affordable, increasingly more employers are directing their efforts to preventing and managing disease in an effort to reduce the costs, not only of direct health care costs, but the real bottom line impact on productivity caused by employee illness and injury. Researchers estimate that 75 percent of all healthcare costs stem from preventable chronic health conditions such as diabetes, hypertension, and obesity.¹⁶

Employers are increasingly taking, or at least considering, proactive measures to make sure their employees have regular physical examinations, information on nutrition and exercise, low or no-cost access to the medications needed to treat chronic illness, behavioral health assistance, and smoking cessation and weight reduction programs.

Many chronic diseases and acute conditions, such as seasonal flu, can be effectively prevented through lifestyle changes, immunizations, preventive medications, or screenings. Despite the benefits of prevention, only half of insured adults receive preventive interventions according to guidelines for their age and sex.¹⁷ Moreover, only 1 percent of the \$1.9 trillion dollars spent

⁸ See notes 5-6, *supra*.

⁹ MASS. GEN. LAWS, Chapter 58 of the Acts of 2006.

¹⁰ Gov. Schwarzenegger Tackles California’s Broken Health Care System, Proposes Comprehensive Plan to Help All Californians, Press Release, Jan. 8, 2007, available at <http://gov.ca.gov/index.php?/press-release/5057>.

¹¹ S.F., CAL., ADMIN. CODE ch. 14 (2007).

¹² S.F., CAL., ADMIN. CODE ch. 12(w) (2007).

¹³ S. 190, 110th Cong. § 2 (2007).

¹⁴ <http://www.johnmccain.com/Informing/Issues/19ba2f1c-c03f-4ac2-8cd5-5cf2edb527cf.htm>

¹⁵ See, <http://www.hillaryclinton.com/feature/healthcareplan/summary.aspx> and <http://www.barackobama.com/issues/healthcare>.

¹⁶ Center for Medicare & Medicaid Services. *National Health Expenditures and Selected Economic Indicators, Levels and Average Annual Percent Change: Selected Calendar Years 1990-2013*. Washington, DC: Center for Medicare & Medicaid Services, Office of the Actuary; 2004.

¹⁷ Institute of Medicine. *The Future of the Public’s Health in the 21st Century*, Washington, DC: National Academy Press; 2002.

on health care in the United States is devoted to protecting health and preventing illness and injury.¹⁸

What can employers do to improve the health, and correspondingly, the well-being and productivity of their employees? Increasingly, employers are moving on a continuum, from voluntary programs that offer information and counseling, to programs that require employees to complete a confidential health risk assessment, to programs that motivate employees to engage in disease management, to programs that require employees to refrain from unhealthy behaviors such as smoking, to wellness programs that require, as a condition of employment, that employees meet benchmarks for risk factors such as blood pressure, cholesterol levels, body mass index (BMI), and blood sugar levels.



PRACTICE POINTER: Effective wellness programs are tailored to the particular employee population. A mine of information is available from historical health claims data, but any analysis of that data should be done by third-party professionals to avoid privacy claims.

A. Examples of Employers that are Taking a Proactive Approach to the Prevention & Management of Employee Wellness

Scotts Miracle-Gro Company. Scotts announced in December 2005 the creation of a company-wide wellness plan, the LiveTotal Health Initiative.¹⁹ Components of the wellness plan include a 24,000 square foot, \$5 million medical and fitness center across the street from headquarters, which employees may use even during work hours, and that is staffed by two full-time doctors, five nurses, a dietician, counselor, two physical therapists, and a team of fitness coaches, with a drive-thru pharmacy for free prescription drugs. Throughout the company, employees who agreed to take a health care self-assessment earned a \$40 per month reduction in their share of insurance premiums. In addition to the health care assessment, an outside management company was retained to scour the physical, mental, and family health histories of nearly every employee and cross-reference that information with insurance claims data. Health coaches identify employees at moderate to high risk, draw up a management

program, and employees who do not follow the recommendations and work with the health coach are required to pay an additional \$67 a month in insurance premiums. One important and controversial component of the wellness plan is a tobacco-free policy that prohibits employees from using tobacco products at any time, on- or off-duty.²⁰ Tobacco-use testing is required of all new hires and is done randomly on the existing workforce; the presence of nicotine is grounds for termination of employment.

As noted in the introduction, one employee, Scott Rodrigues, whose employment was terminated, has challenged that decision. In an order and opinion dated January 30, 2008, the court permitted Rodrigues' action to proceed on two counts: invasion of privacy and violation of ERISA section 510 (29 U.S.C. § 1140). The court dismissed the causes of action for violation of the Massachusetts Civil Rights Act, Massachusetts General Laws ch. 12, § 11, and for wrongful termination in violation of public policy, flatly rejecting Rodrigues' claim that he had a "right to smoke cigarettes in his personal life, outside of the workplace and work hours." The court agreed, as Scotts had argued, that "the public policy of Massachusetts regarding smoking appears more aligned with efforts to suppress or discourage smoking than with protection of the 'right to smoke.'"²¹



PRACTICE POINTER: Scotts Miracle-Gro is one of the pioneers of mandatory employee wellness programs. Employers willing to be on the frontier should consult closely with legal counsel in each of the states where they have employees.

Pitney Bowes Inc.²² Pitney Bowes, a \$5.5 billion global provider of integrated mail and document management solutions with more than 35,000 employees, introduced managed care in 1995 and soon recognized that there were limits to its ability to negotiate the cost of providing employee health coverage. Having done what it could with its vendors, Pitney Bowes turned to a wellness program intended to educate employees to improve their health status. It established the Pitney Bowes Health Care University, an incentive-based program designed to assist employees in improving and maintaining their health, with a focus on five key health habits: no tobacco use, five fruits and vegetables a day, a body mass index of less than 25, 30 minutes

¹⁸ See notes 10 and 11 *supra*.

¹⁹ The description of the *LiveTotal Health Initiative* is taken from the Memorandum of Law in Support of Motion to Dismiss filed by The Scotts Company L.L.C. in *Rodrigues v. The Scotts Company L.L.C.*, *supra* at n.2 and the *Business Week* article referenced in n.1, *supra*.

²⁰ This aspect of the program was only put into effect in states that do not protect an employee's right to smoke.

²¹ *Rodrigues, supra*, at n.2.

²² Information about the Pitney Bowes program was kindly provided by Andrew R. Gold, Executive Director, Global Benefits Design, Pitney Bowes Inc.

of activity a day, and 100 percent seatbelt use. The next step in the program was to bring health care to the employees. On-site medical clinics with services provided by occupational health nurses, nurse practitioners, physician assistants, physicians, and medical assistants were set up through out the United States, some staffed with Pitney Bowes employees and others by third-party providers. Eight-five percent of the clinics' services were directed at primary care and disease management of acute and chronic non-occupational illnesses and injuries; 10 percent to screening and wellness education; and only five percent to workers' compensation illnesses and injuries. Next, specialty clinics for allergy/asthma, sports medicine, gynecology, and gastroenterology were established, along with complementary clinics for physical and occupational therapy, chiropractic care, and massage therapy. A travel medicine program was introduced.

Pitney Bowes' world headquarters includes an on-site pharmacy administered by a third party, for use by employees, dependents, and retirees. The pharmacy arranges for daily deliveries to employees in larger facilities near headquarters; other employees obtain their prescriptions by mail order; in both cases, a three month supply is provided at two months' cost, with reminders sent to employees as refill dates approach. In 2006, based on cumulative data, Pitney Bowes identified the prescription medications most used by employees and, to encourage employees to take the medications as prescribed, set up three levels of co-payment. As is standard in many plans, there is a 10 percent co-payment for generic drugs, but Pitney Bowes also included all name brand drugs for asthma, diabetes, and hypertension, anti-convulsants, osteoporosis therapy, platelet aggregation inhibitors, prenatal vitamins, respiratory spacers, and smoking cessation products. There is no co-payment on all statins for diabetics and those prescribed after a myocardial infarction, angioplasty, or insertion of a stent. Preliminary results showed a six percent decrease in the average annual cost of care for diabetes and a 15 percent decrease for asthma. An added bonus was that the average annual pharmacy costs also decreased as the result of decreased use of drugs used to treat acute episodes and complications.

Pitney Bowes expanded its program for the management of short-term disability claims to include a behavioral health module to manage psychiatric disabilities. Each employee on

leave for a psychiatric disability is assigned to a team consisting of a behavioral health clinical care manager, treatment providers, psychiatrist, the Employee Assistance Program, and a Pitney Bowes disability nurse. Employees on short-term disability receive a comprehensive continuum of care. Reviews with providers are frequent and in-depth and structured in a collaborative coaching and consultative manner. The individualized return-to-work criteria are reviewed based on an agreed upon timeline for follow up with the employee and therapist. Treatment is coordinated with providers by the behavioral health disability care manager through the establishment of review dates and expectations as well as both short-term and long-term goals. Cognitive-behavioral strategies are employed along with close coordination with medical providers as appropriate. A pilot program is planned in which depression screening questions will be part of the initial comprehensive disability assessment. Those with positive results will be assessed further and referred into the Employee Assistance Program or behavioral health benefit plan.²³



PRACTICE POINTER: Pitney Bowes is a good example of an employer that did its homework and tailored its insurance coverage to its employees' needs.

B. The Wellness Program Continuum

Voluntary wellness programs abound. Employers offer discounted gym memberships, provide conference space for Weight Watchers, offer healthy choices in the cafeteria, give flu shots, sponsor health fairs, establish employee assistance programs, and generally try to create cultural and environmental changes that support long-term behavioral change. These programs, in which employee participation is entirely voluntary, present the fewest legal challenges. But employers want to go further and consider mandatory programs. Littler Mendelson has worked with employers on a continuum of mandatory wellness programs, assessing the legal risks as the level of incentive increases. Among the programs we have considered are:

- Requiring employees to undergo a health risk assessment (measurement of blood pressure, cholesterol levels, blood sugars, and body mass index) as a condition of eligibility for enrollment in group health insurance plans. The

²³ Information on the Pitney Bowes behavioral health plan was obtained from the National Business Group on Health, Center for Prevention and Health Services, Behavioral Health Awards Issue Brief (October 2007), at 28-30, available at http://www.wbgh.org/healthtopics/mental_healthaward.cfm. Other employers honored in 2007 for their behavioral health programs included Aetna, Cisco Systems, Inc., Delta Air Lines, Inc., and GlaxoSmithKline.

tests are administered by a third party and no individual information is provided to the employer. The employee is not required to take any measures to improve scores that are not in the desirable range.

- Requiring employees to work with a health coach. If the health risk assessment indicates that the employee is at-risk, a health coach is assigned, with the task of designing a plan and motivating the employee to do what should be done to remediate the health risk. For example, if the agreed-upon health plan is 30 minutes of aerobic exercise every other day, the health coach might provide a form for the employee to keep track of when he or she exercises, and call the employee each week to see how he or she met the identified goals. A health coach might also send a reminder that a prescription should be refilled or certain tests taken.²⁴
- Requiring employees to participate in some form of exercise. Japanese employers have long required workers to begin the day with team calisthenics, as a way to boost the morale, physical conditioning, and camaraderie of the group.²⁵ Employees who decline to participate (except for reasons of disability) would be subject to disciplinary action and possible termination of employment.
- Requiring employees to abstain from tobacco products, both at and away from work. This is the program Scotts pioneered, but others are following.
- Requiring employees to meet specific health metrics. While we know of no employer who has reached this point on the continuum, that does not mean that it is not being considered.

IV. Legal Challenges Presented By Mandatory Wellness Plans

A. Health Insurance Portability and Accounting Act of 1996 (HIPAA)

Generally, HIPAA prohibits ERISA group health plans from discriminating based on a health factor. Health factors include, but are not limited to, health status, medical condition, claims experience, receipt of health care, and medical history. As

examples, nicotine addition and body mass index are considered health factors covered by the HIPAA non-discrimination rules. On December 13, 2006, the Department of Labor and Internal Revenue Service issued final regulations relating to wellness programs that are applicable to wellness plans with a plan year beginning on or after July 1, 2007.²⁶

On February 14, 2008, the U.S. Department of Labor (DOL) issued Field Assistance Bulletin (FAB) No. 2008-02, which includes a Wellness Program Checklist, in response to questions concerning what types of programs must be in compliance with the final HIPAA regulations. The DOL's Wellness Program Checklist is intended to clarify which wellness programs offered by a group health plan must comply with the regulations.

FAB No. 2008-02 now provides guidance in the form of a simple, straightforward checklist that will assist a plan sponsor in determining: (1) whether a group health plan offers a program of health promotion or disease prevention that is required to comply with the final regulations; and (2) whether that program is in compliance with the final regulations. The checklist consists of 10 questions to be answered "yes" or "no," along with examples and tips that serve to clarify the intent and purpose of those questions.

The first five checklist questions establish the period used as the plan year, whether there is a wellness program in place, whether it is part of a group health plan and whether the program discriminates on the basis of a health factor:

1. Is the first day of the current plan year after July 1, 2007?
2. Does the plan have a wellness program?
3. Is the wellness program part of a group health plan?
4. Does the program discriminate based on a health factor?
5. If the program discriminates based on a health factor, is the program saved by the benign discrimination provisions?

If the employer answers "no" to any of the first four questions, it need not continue with the checklist because the plan is not covered by the regulations. If the employer answers "yes" to all five questions, it need not continue with the checklist because the plan is covered by the regulations and is in compliance. A

²⁴ In the Scotts program, the health coach called an executive, an avid cyclist who cycles the 36 mile commute each day and is solid muscle, but whose high protein diet resulted in an undesirable cholesterol score, urging him to undergo a series of diagnostic tests. Tired of the constant calls from the health coach, (and at risk of losing a significant portion of the employer's contribution toward medical insurance), the executive eventually gave in and saw his doctor, only to be rushed to cardiac surgery with a life-threatening 95 percent blockage in two arteries.

²⁵ YORK W. BRADSHAW & MICHAEL WALLACE, *GLOBAL INEQUALITIES* 100 (PINE FORGE PRESS 1996).

²⁶ C.F.R. § 54.9802 *et seq.*

“no” response to the fifth question requires completion of the next section of the checklist regarding compliance criteria:

6. Is the amount of the reward offered under the plan limited to 20 percent of the applicable cost of coverage?
7. Is the plan reasonably designed to promote health or prevent disease?
8. Are individuals who are eligible to participate given a chance to qualify at least once per year?
9. Is the reward available to all similarly situated individuals? Does the program offer a reasonable alternative standard?
10. Does the plan disclose the availability of a reasonable alternative in all plan materials describing the program?

Although the HIPAA regulations addressed discrimination, the FAB makes it clear to employers that the programs must meet either a benign discrimination exception or offer a reasonable alternative standard in order to comply with the final rules. Permissible benign discrimination may be found under a “participation-based” wellness program. This type of program will offer a reward, which is based solely on participation in the program and does not condition the reward on achievement of a specific health-related outcome. Therefore, although the wellness program may “discriminate” in mandating that only certain employees will be required to participate in a particular program (i.e., you must be a smoker to participate in a smoking cessation program), there is no goal that must be met to procure the reward. The FAB offers the example of a plan that grants participants with diabetes a waiver of the annual deductible if they enroll in a disease management program that consists of attending educational classes and following their doctors’ recommendations regarding exercise and medication, concluding that this is benign discrimination because the program is offering a reward to individuals based on an adverse health factor.

The FAB also clarifies how a reasonable “alternative standard” may be required under a program that requires a particular goal be met in order for a reward to be given. This means that although a reward may only be available to those who meet a certain standard (e.g., the attainment of cholesterol target), there must be an alternative standard (e.g., nutrition counseling sessions)

that is made available to those for whom satisfying the otherwise applicable standard is: (1) unreasonably difficult due to a medical condition; or (2) medically inadvisable. The FAB notes that it is permissible for the plan or issuer to seek verification, such as a certificate from the individual’s health care provider, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.



PRACTICE POINTER: A copy of FAB No. 2008-02 appears as Appendix B to this paper.

B. Discrimination Against Persons with Disabilities

Under the Americans With Disabilities Act (ADA), an employer may not discriminate against a qualified individual with a disability with regard to, among other things, employee compensation and benefits available by virtue of employment.²⁷ ADA issues will arise in a mandatory wellness program for three reasons. First, the ADA limits the circumstances under which an employer may ask questions about an employee’s health or require the employee to have a medical examination. Second, the ADA imposes strict confidentiality requirements on the disclosure of medical information. Third, the ADA will certainly apply if an employee is able to perform the essential functions of his or her job but, because of a disability, is unable to achieve a health factor requirement under a mandatory wellness plan.

Medical inquiries or examinations of current employees regarding the existence, nature or severity of a disability are generally prohibited unless job-related and consistent with business necessity.²⁸ All employees are entitled to this ADA protection (i.e., they do not have to be a qualified individual with a disability).²⁹ To avoid the first and second ADA obstacles, most employers that adopt wellness plans retain an independent third party to administer the program. The third-party administrator collects and analyzes all medical information and does not disclose individual health data to the employer.

The EEOC has taken the position that it is permissible to ask for medical information as part of a voluntary wellness program that focuses on early detection, screening, and management of disease.³⁰ A wellness program is “voluntary” so long as an employer

²⁷ 42 U.S.C. §12112(a), (b).

²⁸ 42 U.S.C. § 12112(d)(4)(A).

²⁹ See, e.g., *Conroy v. New York State Dep’t of Corr. Servs.*, 333 F.3d 88, 94 (2d Cir. 2003); *Fredenburg v. Contra Costa Co. Dep’t of Health Servs.*, 172 F.3d 1176, 1182 (9th Cir. 1999).

³⁰ 42 U.S.C. §12112(d)(4).

neither requires participation nor penalizes employees who do not participate.³¹ Information collected during the permissible inquiries or examinations must be maintained in separate medical files and treated as confidential medical information.³² While the EEOC's position implicitly suggests that it would not reach the same conclusion for a mandatory program, when the program only requires the employee to participate in a health assessment and does not require the employee to achieve any specific health standard and only the third-party administrator has the individual's medical data, the same conclusion should be reached.

But what if the wellness plan mandates that employees achieve some measurable health standard as a condition of employment? While at the riskier edge of the wellness continuum, the concept of a reasonable accommodation, both under the ADA and the HIPAA regulations, suggests that even the third obstacle can be overcome. The employee may be able to meet a less stringent health factor or be given the alternative of participating in a program designed to manage or mitigate the medical condition. If a physical or mental disability prevents an employee from participating in such an alternative, and the employee is able to perform the essential functions of the job, a waiver may be necessary. Obviously, an employer that learns of a mandatory health assessment will need to take extra precautions to assure that the knowledge obtained in the health assessment truly is not used as the basis for an adverse employment action.

Employers should also be mindful that not all at-risk health conditions are tied to a disability. An employee's excess weight may be tied to poor diet and exercise habits, not an endocrine imbalance. Smoking, excessive drinking (short of alcoholism), and recreational drug use (short of addiction) are poor health habits that are not per se protected by the ADA.

An employer might also argue that the wellness program does not discriminate on the basis of disability because its terms apply equally to the disabled and nondisabled. This defense has been discussed in a handful of cases with respect to employee benefits plans.³³ The employer might also defend an ADA claim by arguing that the wellness program was implemented for underwriting,

classifying or administering risks.³⁴ However, an employer may not use risk-assessment activities as a subterfuge to evade the ADA's nondiscrimination requirements (e.g., refusing to hire disabled persons solely because their disabilities may increase the employer's future health care costs; or denying disabled employees equal access to health insurance based on disability alone, if the disability does not pose increased insurance risks).³⁵



PRACTICE POINTER: The intersection of disability discrimination and obesity requires careful attention. Obesity is not necessarily a disability, although it can be. Obese employees are the ones most likely to have associated health risks and least likely to conform to a diet and exercise regimen. Employers must also be mindful of local ordinances prohibiting discrimination on the basis of height and weight.

C. Age Discrimination in Employment Act (ADEA)

A mandatory wellness program can be crafted to correspond to the reasonable expectations of the older worker. Wellness programs do not demand that employees become super athletes or achieve perfect health. If a mandatory program requires an employee to achieve a certain health standard, that standard should take into account, and if necessary, be adjusted for, the age of the employee. Programs can mandate participation in an exercise or fitness program without requiring, for example, that everyone be able to run a certain distance at a certain speed.



PRACTICE POINTER: As we age, we are at increased risk for many diseases and injuries. As more and more workers continue to work past "normal" retirement age, employers will have additional motivation to work with their employees to prevent illness and injury.

D. Title VII

In addition to age, some of the classes protected by Title VII and similar state laws may be implicated in a mandatory wellness program. Gender and religion come to mind, but again, reasonable accommodation should lessen the risk of litigation.

³¹ *Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans With Disabilities Act (ADA)*, available at www.eeoc.gov/policy/docs/guidance.

³² 42 U.S.C. §12112(d)(3)(B), (4)(C).

³³ *EEOC v. Staten Island Sav. Bank*, 207 F.3d 144 (2d Cir. 2000) (in the context of a long term disability plan, offering different benefits for mental and physical disabilities does not violate the ADA, because every employee was offered the same plan regardless of disability status); *Krauel v. Iowa Methodist Med. Ctr.*, 915 F.Supp. 102 (S.D. Iowa 1995) (health plan's exclusion for infertility treatments was not a distinction based on disability, because it applied to individuals who did and did not have disabilities).

³⁴ 42 U.S.C. §12201(c)(2), (3).

³⁵ 42 U.S.C. §12201(c)(2). See, e.g., *Barnes v. Benham Group, Inc.*, 22 F. Supp. 2d 1013 (D. Minn. 1998) (holding in favor of the employer on an ADA claim, where the employer terminated an employee who refused to complete a health insurance enrollment form, because the form was used by the insurer to classify or underwrite risk); *McLaughlin v. General Am. Life Ins.*, 1998 U.S. Dist. LEXIS 16994 (E.D. La. Oct. 21, 1998) (preexisting condition limitation excluding payment of claims for which the insured had been treated during the previous 12 months did not violate ADA).

If specific health standards are set, an employer must be able to objectively demonstrate with reliable expert data that the standards do not discriminate against women. In the early 1980s, many airlines' weight limitations for flight attendants were challenged because they were overly restrictive when it came to women, allowing more tolerance for excess weight in male flight attendants. Wellness programs should set goals based on what is a healthy weight, even if a female employee might look more attractive if she were thinner than that weight. There are generally accepted BMI standards based on age and gender that could be incorporated into a wellness program. Women carry a greater percentage of body fat than do men and that is factored into the BMI.

Religion could be a challenge if, in order to manage a health risk, an employee should be on medication but, for religious reasons, the employee does not take medication. If medication were the only way the employee could achieve a stated health standard, a reasonable accommodation would have to be offered. For example, an employee with high blood pressure may not be able to get his or her blood pressure into a normal range without medication, but may be able to reduce it somewhat with diet and exercise, even though it remains higher than desired levels.

E. National Labor Relations Act (NLRA)

Employers in a unionized environment may also face significant challenges in implementing a wellness program. According to the National Labor Relations Act (NLRA), employers must bargain in good faith over mandatory subjects of bargaining, defined to include wages, hours, and other terms and conditions of employment. Given that many wellness programs are likely to impact an employee's wages (via reduced health premiums) and mandatory programs certainly will impact the terms and conditions of employment, an employer in a union environment most likely will not be able to unilaterally implement a wellness program. Rather, such employers likely will be required to propose their wellness program to the union and engage in bargaining over the terms of the program.

Employee benefits such as health insurance plans are mandatory subjects of bargaining.³⁶ Thus, should an employer's wellness program change the structure of employee contributions,

co-pays, and deductibles, or offer new programs on topics such as smoking cessation and weight loss, the employer will likely be required to bargain over such changes.

In addition, the National Labor Relations Board (NLRB) has held that health and safety issues are mandatory subjects of bargaining. For example, the Board has held that an employer must bargain over its implementation of a non-smoking policy.³⁷ Thus, should an employer's wellness program seek to restrict on-site use of tobacco products, the employer will likely need to bargain with the union over such a decision.

Some wellness programs might also require that employees submit to physical examinations. These aspects of the program must also be bargained with a union.³⁸ Accordingly, cholesterol, blood pressure, and other types of physical examination programs are likely mandatory subjects of bargaining. Even an employer's decision to significantly change dining alternatives in its cafeteria may also trigger its duty to bargain with the union, particularly where services are altered or prices affected.³⁹

An employer in a union environment should consider these obligations in conjunction with its overall bargaining strategy. The experience of the DaimlerChrysler/United Auto Workers National Wellness program may set a precedent that other unions would be willing to follow. That program is a negotiated benefit that was formed through an alliance between DaimlerChrysler management and the autoworkers' union. Through the program, management and labor work together with third-party providers to make health-promotion and prevention initiatives available to employees.



PRACTICE POINTER: DaimlerChrysler and the UAW's Stay Well program is an excellent example of management and labor taking a proactive approach to managing health care costs, often the most tenacious subject of bargaining and increasingly a benefit workers are willing to strike over.

F. Privacy & Other Statutes

A number of states have enacted laws that must be considered when designing a mandatory wellness program. While this is not

³⁶ *Hardesty Co., Inc. d/b/a Mid-Continent Concrete Co.*, 336 NLRB 157, enforced 308 F.3d 859 (8th Cir. 2002) (employer violated 8(a)(5) by unilaterally changing the health insurance benefit plan); *Brook Meade Health Care Acquirers*, 330 NLRB 775 (2000) (unilateral increase in employee contributions to health insurance premiums constitutes a violation of the NLRA).

³⁷ *See-Tech Corp.*, 309 NLRB 3 (1992), *aff'd sub nom. NLRB v. High Tech. Cable*, 25 F.3d 1044 (5th Cir. 1994) (management rights provision relied on by employer not sufficient to constitute clear and unequivocal waiver of union's right to bargain over specific no-tobacco rule); *Allied Signal, Inc.*, 307 NLRB 752 (1992) (union's agreement to "safety and health" clause was deemed conscious waiver of union's right to bargain prior to employer's implementation of new policies affecting health and safety, such as change in smoking policy).

³⁸ *Colgate-Palmolive Co.*, 323 NLRB 515 (1997); *Leroy Mach. Co.*, 147 NLRB 1431 (1964) (management-prerogatives clause constituted union waiver of right to require employer to bargain about physical examinations during term of existing agreement).

³⁹ *Mercy Hosp. of Buffalo*, 311 NLRB 869 (1993) (elimination of late night cafeteria service); *O'Land, Inc.*, 206 NLRB 210 (1973) (employer violated section 8(a)(5) by unilaterally granting free meals to non-striking employees; the employer failed to notify employees that the free meals were a temporary measure for the purpose of protecting nonstriking employees).

an all-inclusive list of every state statute that might be triggered by a wellness program, it should serve as an important reminder to engage local counsel in the states where the employer does business, in the process of designing and implementing any wellness program.

1. State Health Information Privacy Statutes

California, Hawaii, Maine, Maryland, Minnesota, and Wisconsin have comprehensive statutory schemes regulating how employers may use and disclose employee health information. Employers in these states may have to use a third-party administrator to conduct their wellness programs. As one example, California's statute requires employers to establish procedures to protect the confidentiality of an employee's medical information and limits how employee health information may be used and disclosed without the employee's authorization. The latter requirement would bar the disclosure to managers of health information generated by a mandatory wellness program. Moreover, employers are barred from retaliating against an employee who refuses to sign an authorization for disclosure, although an employer may take actions necessitated by the lack of information resulting from the employee's refusal. The statute also imposes requirements on the form and content of an authorization.

2. State Laws Prohibiting Adverse Action on the Basis of Lawful Off-Duty Conduct

A growing number of states have enacted statutes prohibiting employers from taking adverse employment action for lawful off-duty conduct. While using tobacco or drinking too much is unhealthy, it is not illegal. In these states, employers must be careful not to implement mandatory wellness programs, or even target goals within those programs, that permit adverse employment action based on an employee's failure to abstain from smoking. In several states (Colorado and New York, for example), the prohibition extends to virtually any lawful off-duty conduct that does not conflict with the employer's interests. Thus, an employer could not take adverse action in those states against an employee who overeats while off duty and cannot meet weight-loss objectives.

The scope of these state laws should be examined carefully before a mandatory wellness program is put in place so that an

employer can determine the types of "carrots and sticks" that would be permissible. Colorado's statute, for example, prohibits termination based upon lawful, off-duty conduct, but does not bar other types of adverse employment action. Thus, discipline short of termination based on the failure of employees to conform off-duty conduct to wellness program requirements might be permissible even in states that provide protections for lawful off-duty conduct.

3. State Laws Prohibiting Adverse Action Based on the Results of Genetic Testing

Employers implementing mandatory wellness programs that include genetic testing must also comply with myriad state laws. More than one-half of all states have implemented statutes regulating whether and how employers may obtain, use, and disclose genetic information.

By way of example, Massachusetts has enacted a comprehensive genetic testing statute. The statute bans genetic testing without informed consent and further requires written consent for the disclosure of any reports or other records containing genetic information. Massachusetts' law goes so far as to establish that genetic composition is a protected characteristic under the state's antidiscrimination statute. Therefore, in Massachusetts, employers must be careful before implementing an employee medical screening initiative that evaluates an employee's propensity for genetically linked medical conditions, such as sickle-cell anemia or certain types of cancer.

Due to the diversity among state laws, multi-state employers, in conjunction with experienced counsel, should evaluate the effect of state genetic testing laws before implementing a mandatory wellness program.



PRACTICE POINTER: Because state laws vary widely and there is often little case law to provide guidance, employers should be sure to work with local counsel in each state where there are employees. Wellness is encouraged as a matter of public policy, particularly as states find themselves picking up a larger and larger share of providing health care to the uninsured. The state's interest in preserving and improving public health can be balanced against the individual's right of privacy.

G. Constitutional Concerns for Public Entities

The Eastern District of Michigan has been one of the first courts to address a wellness program. In *Anderson v. City of Taylor*,⁴⁰ the City of Taylor Fire Department implemented a wellness program that included a free membership for each employee to the city's recreational facility, free rounds of golf at the city-owned golf courses, blocks of ice time at the city's arena, and a health appraisal. The health appraisal included a mandatory blood draw, which was used to determine cholesterol levels. The plaintiff firefighters sued, claiming that the blood draws violated their constitutional rights, including their Fourth and Fourteenth Amendment rights to be free from unreasonable searches and seizures. The union filed a grievance on behalf of the plaintiffs, stating that the blood draw violated their collective bargaining agreement. The court denied the city's motion for summary judgment and, as a result of the union's grievance, the fire department abandoned the blood draws.

V. Future Developments Addressing Wellness Programs

A. Recent State Wellness Related Legislation

Perhaps recognizing that widespread employer wellness programs are inevitable, Congress and many state legislatures have begun addressing the issue of employee wellness in proposed legislation. Although the legislation ranges in scope and specifics, it is clear that state legislatures have noticed the increasing trend towards employee wellness and the benefits associated with such programs.

Some states, recognizing the trend towards wellness programs that seek to reduce or eliminate smoking and obesity, have moved towards providing additional protections for employees. Massachusetts legislators have proposed adding height and weight as protected classes for purposes of discrimination in employment and housing.⁴¹ Though the bill has been introduced

several times and not passed, each time it gathers political steam.⁴² Massachusetts would join Michigan, the District of Columbia, Santa Cruz, California, and San Francisco, California as locations that have prohibited discrimination on the basis of weight.

Smoking in the workplace has attracted perhaps the most attention from the states. Numerous states have introduced legislation designed to prohibit or more strictly regulate smoking in workplaces and public places.⁴³ In November 2006, almost 55 percent of Arizona voters approved the Smoke Free Arizona Act (Proposition 201) and, as of May 1, 2007, smoking was banned in all workplaces in Arizona.⁴⁴ On January 1, 2008, the Smoke Free Illinois Act took effect, banning smoking in virtually all public places.⁴⁵ As of February 1, 2008, Maryland extended the state's smoking ban to bars, restaurants, and private social clubs.⁴⁶ On February 27, 2008, the Iowa Senate approved a ban on smoking that will protect nearly every Iowa worker from second-hand smoke.⁴⁷ (Because the House version of the bill would have exempted casinos, the bill has been returned to the House for further debate.) On June 26, 2007, Oregon enacted the Clean Air Act, effective January 1, 2009, which will ban smoking in virtually all enclosed public spaces.⁴⁸ Massachusetts, which banned smoking in all workplaces in 2004, recently enacted landmark legislation that, in addition to requiring that all residents have some form of insurance coverage as of July 1, 2007, will establish a state program to subsidize the cost of smoking cessation products.⁴⁹ Effective June 15, 2007, the Dee Johnson Clean Indoor Air Act prohibits smoking in all New Mexico indoor workplaces and the entrances to those buildings.⁵⁰ Similarly, Indiana increased the tax on cigarettes, with some of the additional revenue to be used for smoking cessation programs.⁵¹ Effective October 1, 2007, it is illegal to smoke in most Tennessee workplaces, a result of the Tennessee Non-Smokers Protection Act.⁵² Also as of October 1, 2007, smoking is prohibited in all Minnesota indoor and in-home

⁴⁰ 2006 U.S. Dist. LEXIS 38075 (E.D. Mich. June 9, 2006).

⁴¹ H.R. 1844, 115th Gen. Ct., Reg. Sess. (Mass. 2007).

⁴² Dan RING, HEIGHT, WEIGHT WAS SEEN AS LATEST DISCRIMINATION, MASS., THE REPUBLICAN, Mar. 25, 2008, available at http://www.masslive.com/news/index.ssf/2008/03/height_weight_bias_seen_as_lat.html.

⁴³ See, e.g., S. 155, 2007 Leg., Reg. Sess. (Ala. 2007); R.45, 2007 Council, Reg. Sess. (D.C. 2007); B. 187, 2007 Council, Reg. Sess. (D.C. 2007); H.S.B. 24, 2007 Gen. Assem., Reg. Sess. (Iowa 2007); S. 36 2007 Gen. Assem., Reg. Sess. (Iowa 2007); H. 246, 95th Gen. Assem., Reg. Sess. (Ill. 2007); H. 305, 85th Leg. Reg. Sess. (Minn. 2007); S. 238, 85th Leg. Reg. Sess. (Minn. 2007); H. 259, 2007-2008 Gen. Assem., Reg. Sess. (N.C. 2007); S. 2164, 60th Leg., Reg. Sess. (N.D. 2007); H. 2016, 74th Leg. Assem., Reg. Sess. (Ore. 2007); S. 354, 74th Leg. Assem., Reg. Sess. (Ore. 2007); H. 720, 2007 Gen. Assem., Reg. Sess. (Pa. 2007).

⁴⁴ ARIZ. REV. STAT. ANN. §36-601.01 (2007).

⁴⁵ 410 ILL. COMP. STAT. 82/1 et seq. (2007).

⁴⁶ MD. CODE ANN. § 24-205 (2007).

⁴⁷ S. 5036, Gen. Ass. (Iowa 2008).

⁴⁸ SB 571, 2007 Gen. Sess. (Or. 2007).

⁴⁹ H. 997, 115th Gen. Ct., Reg. Sess. (Mass. 2007).

⁵⁰ N.M. STAT. § 24-16-1 (2007).

⁵¹ S. 565, 115th Gen. Assem., 1st Reg. Sess. (Ind. 2007).

⁵² TENN. CODE ANN. §39-17-1801 et seq. (2007).

workplaces by the Freedom to Breathe Act of 2007.⁵³ In February 2008, the Nebraska legislature passed a statewide smoking ban that will go into effect on June 1, 2009.⁵⁴ Although North Carolina never had a statewide ban on smoking, and in 1993 enacted a law prohibiting any local law, rule, or ordinance banning smoking, except for those in effect on October 15, 1993, (and which could not be amended to provide more stringent standards),⁵⁵ that law was repealed effective January 1, 2008⁵⁶ and, as of that date smoking is banned in all state government buildings and local governments are free to restrict smoking in public places.⁵⁷

These states join those that previously enacted statewide laws banning smoking in most workplaces: Arkansas, California, Colorado, Connecticut, Delaware, Florida, Louisiana, Massachusetts, Montana, Nebraska, Nevada, North Dakota, Ohio, Rhode Island, South Dakota, Vermont, and Washington. Some of the states not listed have laws restricting smoking in some workplaces, (e.g., restaurants and child care centers), or have local ordinances banning smoking in the workplace (e.g., West Virginia has local bans of varying degree in all 55 counties).

The Kansas legislature has twice rejected a statewide smoking ban, once in January 2007 and again in August 2007.⁵⁸ A proposal for a statewide ban on smoking was proposed for the first time in Missouri in February 2008, but the bill has no co sponsors and little support.⁵⁹



PRACTICE POINTER: There is no question that limitations on smoking are the “hot button” of wellness programs. At one time, smoking in the workplace was common. Today, there are very few workplaces, and places of public accommodation, where smoking is allowed. Tomorrow, we will see more and more employers who will not hire smokers.

Last year Littler reported that wellness programs also are receiving attention at the federal level. The Wellness and Prevention Act that would offer employers tax credit if the employer implements a wellness program has languished in the House Subcommittee on Health since February 2007.⁶⁰ If the law passes, in order to qualify for the tax credit, the employer’s program must:

- Be implemented by the eligible employer in consultation with an individual who has implemented a wellness program for a different employer and who will ensure compliance with appropriate measures to protect the privacy of program participants;
- Conduct health risk assessments for each of the program’s participants;
- Offer at least two of the preventive services strongly recommended by the U.S. Preventive Services Task Force on an annual basis;
- Offer annual counseling sessions and seminars related to at least three of the following: (1) smoking, (2) obesity, (3) stress management, (4) physical fitness, (5) nutrition, (6) substance abuse, (7) depression, (8) mental health, (9) heart disease, and (10) maternal and infant health; and
- Have at least 50 percent of eligible full-time employees participate in the program.⁶¹

The Genetic Information Nondiscrimination Act of 2007 passed the House, but no action has been taken by the Senate since April 2007.⁶² Should it pass, employers will be prohibited from requesting, requiring, or purchasing genetic information unless:

- Health or genetic services are offered by the employer as part of a bona fide wellness program;
- The employee provides prior, knowing, voluntary, and written authorization;
- 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
- Any individually identifiable genetic information provided is only available for 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.

⁵³ MINN. STAT. § 82.14 (2007).

⁵⁴ LB 395, 100th Leg., 2d Reg. Sess. (Neb. 2008).

⁵⁵ N.C. GEN. STAT. § 143-601 (1993).

⁵⁶ N.C. Sess. Laws 2007-193, s. 3.

⁵⁷ NC. GEN. STAT. §130A-491 *et seq.* (2008).

⁵⁸ *Kansas Panel Rejects Call for Statewide Smoking Ban*, KAN. CITY STAR, Aug. 30, 2007.

⁵⁹ S. 1079, 94th Gen. Ass. (2008)

⁶⁰ H.R. 853, 110th Cong. (2007).

⁶¹ *Id.*

⁶² See H.R. 493, 110th Cong. (2007); S. 358, 110th Cong. (2007).

B. Recent Federal Wellness Related Legislation

Last year we reported that several state legislatures had proposed legislation providing tax incentives to employers that create and maintain wellness programs for their employees. To date, only Indiana has passed such a law, which applies to employers that employ between two and 100 employees.⁶³ The employer must have its wellness plan certified by the state and, to obtain certification, must include components for employee appropriate weight loss, smoking cessation, and pursuit of preventable health care services. The employer must submit, for each component, a written description of how it conducts assessments, what educational materials are provided to employees, what rewards are provided to employees, and what measurement tool is used to evaluate the success and validity of the program.⁶⁴ The legislation introduced in Florida died in committee,⁶⁵ but the bills introduced in California,⁶⁶ New Jersey,⁶⁷ and New York⁶⁸ would offer employers tax credits for qualified fitness expenditures. Although the specifics of each bill vary, the following are examples of qualified fitness expenditures:

- The costs associated with operating and maintaining a gymnasium, weight training room, aerobics workout space, swimming pool, running track or other site used for competitive sports events or games;
- The cost of equipping or sponsoring an amateur athletic team that engages in “vigorous athletic activity;”
- Subsidizing an employee’s membership in a health club;
- 50 percent of the cost of employing an individual or organization to provide information on subjects relating to personal health and hygiene and opportunities for fitness enhancement activities, including stretching, aerobics, yoga, etc.; and
- The costs associated with hiring an organization to operate an employee fitness facility, provide fitness equipment or employee fitness instruction at the employer’s workplace.

Other states have proposed the creation of task forces to study the various issues associated with employee obesity and employer wellness programs.⁶⁹

We continue to monitor the implementation of a wellness program for all MassHealth⁷⁰ enrollees.⁷¹ The wellness program, which went into effect as of July 1, 2007, is designed to address smoking cessation, diabetes screening for early detection and stroke education. Enrollees complying with the wellness program will receive reduced premiums and/or co-pays.⁷²

Federal organizations are also responding to the trend towards employer wellness programs. The Occupational Health and Safety Administration (OSHA) recently extended its alliance with the American Heart Association (AHA). Among the goals of the alliance are to continue to provide health and wellness information to employers.⁷³ The alliance has recently focused on programs designed to help employers prepare for medical emergencies and provide training about the use of automated external defibrillators, CPR, and first aid.

VI. Wellness Programs & the Law in 2010 and Beyond

In 2001, the U.S. Department of Health and Human Services published “Healthy Workforce 2010: An Essential Health Promotion Sourcebook for Employers, Large and Small.” The forward-thinking report observed that “[w]orksites, where most adults typically spend half or more of their waking hours, have a powerful impact on individuals’ health.” Two ambitious goals were established: (a) 75 percent of employers (large and small) were to offer a comprehensive employee health promotion program; and (b) 75 percent of employees would be participating in employer-sponsored health promotion activities. Four reasons were provided: (1) improved productivity; (2) lower health care costs; (3) enhanced corporate image (associated with wellness); and (4) help the nation achieve its health objectives for 2010. Healthy People 2010 includes 467 objectives to be accomplished by the end of the first decade of this century. Without question the scientific and demographic evidence speaks with a single

⁶³ IND. CODE 6-3.1 *et seq.*

⁶⁴ IND. CODE 6-3.1-31.2.3.

⁶⁵ H. 325, 2007 Leg. Reg. Sess. (Fla. 2007); S. 194, 2007 Leg., Reg. Sess. (Fla. 2007).

⁶⁶ A. 1439m, 2007 Leg. Reg. Sess. (Cal. 2007).

⁶⁷ A. 990, 212th Leg., 2006 Sess. (N.J. 2007); S. 527, 212th Leg., 2006 Sess. (N.J. 2007).

⁶⁸ S. 2595, 2007-2008 Leg., Reg. Sess. (N.Y. 2007).

⁶⁹ A. 4316, 2007-2008 Leg. Reg. Sess. (N.Y. 2007); S. 2433, 2007-2008 Leg. Sess. (N.Y. 2007); S. 72, 80th Leg., Reg. Sess. (Tex. 2007); S. 445, 80th Leg., Reg. Sess. (Tex. 2007); H.C.R. 4, 115th Gen. Assem. 1st Reg. Sess. (Ind. 2007).

⁷⁰ The MassHealth program provides comprehensive health insurance or help in paying for private health insurance to nearly one million Massachusetts children, families, seniors, and people with disabilities.

⁷¹ 2006 Mass. Act. Ch. 58, available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

⁷² *Id.*

⁷³ OSHA and AHA, *Alliance Annual Report*, Jan. 22, 2007, available at http://www.osha.gov/dcsp/alliances/aha/annual_report_2005-2006.htm.

voice “that many of the leading causes of disability and premature death in the United States are potentially avoidable or controllable, including most injuries, many serious acute and chronic conditions, and many forms of heart disease, and some cancers.” When this opportunity for “wellness” is added to the projected doubling of health care costs by 2016 and the coming unprecedented shortage of skilled workers, the massive promotion of health in the workplace is certain.

Whether the aggressive 2010 targets are achieved is less important than the fact that targets have been identified and received government approval. The economic and social forces supporting this initiative are so substantial that legal roadblocks can do no more than offer temporary delays and minor changes in direction. Smoking is a case study, as increasingly aggressive countermeasures are legally sanctioned in the workplace. While it is questionable whether testing for nicotine (a lawful substance) will receive legal approval, employer-sponsored programs prohibiting smoking in the workplace and discouraging smoking in the workforce are already sanctioned. Obesity is now a prime target along with physical inactivity. The role of regulation and law in the coming battle will not be one of stopping the inevitable, but rather protecting the individual from harassment and the unnecessary loss of privacy.

Three touchstones are envisioned to shape laws and regulations as the year 2010 approaches. First, increasingly aggressive wellness programs will enter the workplace as long as they provide a substantial and measurable return on investment.⁷⁴ The benefits of employer wellness programs are well documented. One study found the annual per participant savings to be \$613, while private companies have reported returns of as much as \$4.50 in lowered medical expenses for every dollar spent on health programs.⁷⁵

Second, aggressive support for such programs will require that implementation occur without avoidable harassment of individuals. As harassment law extends the reach of protected categories and includes an increasing share of “rude and offensive” behavior in the workplace, protections for the dignity of obese and inactive employees will grow. We already see this in case law prohibiting harassment where the impact is greater

on one gender.⁷⁶ While it may seem like a contradiction that an employer can maintain a health fitness program targeting obesity while protecting overweight employees from rude or demeaning treatment, this is exactly what the future promises. In a sense, this is no more complex than applying the golden rule to wellness. Almost all people want “wellness,” yet few want to be insulted or teased in their efforts to become well.

Third, the wellness initiative will require seeking and then protecting highly personal and confidential information from employees, such as their deepest health secrets. This is the exact information that if attributed to the employer would lead to litigation ranging from disability discrimination to invasion of privacy. The solution will involve the rise of third party health program administrators, in particular, professional organizations that can collect information from employees and release to employers only what is needed for the wellness program. The role of this new industry will be critical in achieving workplace wellness. Some abuses may likely take place due to an initial lack of professionalism on the part of some of the new entrants into the industry as well as a lack of established procedures. This transition will be temporary as quality improves and government assists in institutionalizing the role of the third party health program administrators.

Employers need to anticipate the future as they balance business needs and compliance challenges and risk. An initial wellness program should be reviewed semi annually to measure legal compliance and the opportunity for new features as case law, regulations, and statutes develop and change. As wellness programs emerge and mature, there will be more guidance available, but employers should not wait until the decisions are in to start developing and implementing wellness plans. We will continue to watch OSHA initiatives, including those arising from the AHA alliance. Littler also will follow and report on developments under the ADA, ERISA, HIPAA, and the workers’ compensation arena, as well as constitutional and state law implications. The fact that more and more employers are introducing wellness programs, yet there has been little litigation, underscores that a compliant wellness program can be implemented; the challenge will be to move on the continuum from voluntary to mandatory and remain in compliance.

⁷⁴ See, e.g., *Wellness Programs Are Worth Every Dollar You Spend*, St. Louis Bus. J., Mar. 31, 2007.

⁷⁵ See, e.g., Gregg H. State, et al., *Quantifiable Impact of the Contract for Health Wellness; Health Behaviors, Health Care Costs, Disability and Workers’ Compensation*, 45 J. OF OCCUPATIONAL & ENVIRON. MED. 109-117 (2003); Morgan O’Rourke & Laura Sullivan, *A Health Return on Employee Investment*, 50:11 RISK MANAGEMENT 34-38 (2003); Rachel Christensen, *Employment-Based Health Promotion and Wellness Programs*, 22:7 EBRI NOTES 1-6 (2001); Steven G. Aldana, *Financial Impact of Wellness Programs: A Comprehensive Review of the Literature*, 15:5 AM. J. OF HEALTH PROMOTIONS 296-300 (2001).

⁷⁶ In *EEOC v. National Educ. Ass’n*, 422 F.3d 840 (9th Cir. 2005), the court held that screaming and yelling by men at work may be gender-based discrimination even if there is no sexual context to the behavior.

Appendix A

Treas. Reg. § 54.9802-1

Effective: February 12, 2007

Code of Federal Regulations Currentness Title 26. Internal Revenue

Chapter I. Internal Revenue Service, Department of the Treasury

Subchapter D. Miscellaneous Excise Taxes

Part 54. Pension Excise Taxes (Refs & Annos)

§ 54.9802-1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) Health factors.

(1) The term **health factor** means, in relation to an individual, any of the following health status-related factors:

- (i) Health status;
- (ii) Medical condition (including both physical and mental illnesses), as defined in § 54.9801-2;
- (iii) Claims experience;
- (iv) Receipt of health care;
- (v) Medical history;
- (vi) Genetic information, as defined in § 54.9801-2;
- (vii) Evidence of insurability; or
- (viii) Disability.

(2) Evidence of insurability includes

- (i) Conditions arising out of acts of domestic violence; and
- (ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 54.9801-6, a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) Prohibited discrimination in rules for eligibility

(1) In general

(i) A group health plan may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to

- (A) Enrollment;
- (B) The effective date of coverage;
- (C) Waiting (or affiliation) periods;
- (D) Late and special enrollment;
- (E) eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.
- (ii) Conclusion. In this Example 1, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2

- (i) Facts. Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: An indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.
- (ii) Conclusion. In this Example 2, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3

- (i) Facts. Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.
- (ii) Conclusion. In this Example 3, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 4

- (i) Facts. A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual A is an employee of the employer maintaining the plan. A and A's dependents have a history of high health claims. Based on the information about A and A's dependents, the issuer excludes A and A's dependents from the group policy it offers to the employer.
- (ii) Conclusion. See Example 4 in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of A and A's dependents from coverage is a

rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for A and A's dependents through other means, the plan violates this paragraph (b)(1).

(2) Application to benefits

(i) General rule

- (A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.
- (B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under ERISA, the Americans with Disabilities Act, or any other law, whether State or Federal.)
- (C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
- (D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1

- (i) Facts. A group health plan applies a \$500,000 lifetime limit on all benefits to each participant or beneficiary covered under the plan. The limit is not directed at

individual participants or beneficiaries.

- (ii) Conclusion. In this Example 1, the limit does not violate this paragraph (b)(2)(i) because \$500,000 of benefits are available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2

- (i) Facts. A group health plan has a \$2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. Participant B files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a \$10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.
- (ii) Conclusion. The facts of this Example 2 strongly suggest that the plan modification is directed at B based on B's claim. Absent outweighing evidence to the contrary, the plan violates this paragraph (b)(2)(i).

Example 3

- (i) A group health plan applies for a group health policy offered by an issuer. Individual C is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about C's adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that C has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for C for that condition. The exclusionary rider is made effective the first day of the next plan year.
- (ii) Conclusion. See Example 3 in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under this paragraph (b)(2)(i) because benefits for C's condition are available to other individuals in the group of similarly situated individuals that includes C but are not available to C. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates the rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i). If the plan provides coverage through this policy and does not provide equivalent coverage for C through other means, the plan violates this paragraph (b)(2)(i).

Example 4

- (i) Facts. A group health plan has a \$2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 4, the limit does not violate this paragraph (b)(2)(i) because \$2,000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific

disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries. (This example does not address whether the plan provision is permissible under the Americans with Disabilities Act or any other applicable law.)

Example 5

- (i) Facts. A group health plan applies a \$2 million lifetime limit on all benefits. However, the \$2 million lifetime limit is reduced to \$10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.
- (ii) Conclusion. In this Example 5, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

Example 6

- (i) Facts. A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 6, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7

- (i) Facts. Under a group health plan, doctor visits are generally subject to a \$250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 7, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 8

- (i) Facts. An employer sponsors a group health plan that is available to all current employees. Under the plan, the medical care expenses of each employee (and the employee's dependents) are reimbursed up to an annual maximum amount. The maximum reimbursement amount with respect to an employee for a year is \$1500 multiplied by the number of years the employee has participated in the plan, reduced by the total reimbursements for prior years.
- (ii) Conclusion. In this Example 8, the variable annual

limit does not violate this paragraph (b)(2)(i). Although the maximum reimbursement amount for a year varies among employees within the same group of similarly situated individuals based on prior claims experience, employees who have participated in the plan for the same length of time are eligible for the same total benefit over that length of time (and the restriction on the maximum reimbursement amount is not directed at any individual participants or beneficiaries based on any health factor).

(ii) Exception for wellness programs.

A group health plan may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment, or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(iii) Specific rule relating to source-of-injury exclusions

- (A) If a group health plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.
- (B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1

- (i) Facts. A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Because of depression, Individual D attempts suicide. As a result, D sustains injuries and is hospitalized for treatment of the injuries. Under the exclusion, the plan denies D benefits for treatment of the injuries.
- (ii) Conclusion. In this Example 1, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of D's injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2

- (i) Facts. A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant E sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for E's head injury.
- (ii) Conclusion. In this Example 2, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However,

if the plan did not allow E to enroll in the plan (or applied different rules for eligibility to E) because E frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(3) Relationship to § 54.9801-3.

- (i) A preexisting condition exclusion is permitted under this section if it
 - (A) Complies with § 54.9801-3;
 - (B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and
 - (C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
- (ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1

- (i) Facts. A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 54.9801-3. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 1, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with § 54.9801-3 (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2

- (i) Facts. A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.
- (ii) Conclusion. In this Example 2, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups

(c) Prohibited discrimination in premiums or contributions

(1) In general

- (i) A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.
- (ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) Rules relating to premium rates

(i) Group rating based on health factors not restricted under this section.

Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) List billing based on a health factor prohibited.

However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) Examples.

The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F's claims experience.
- (ii) Conclusion. See Example 1 in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F's claims experience.

Example 2

- (i) Facts. Same facts as Example 1, except that the issuer quotes the employer a higher premium rate for F, because of F's claims experience, than for a similarly situated individual.
- (ii) Conclusion. See Example 2 in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for F than for a similarly situated individual, see Example 2 in 29 CFR 2590.702(c)(2) and 45 CFR

146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) Exception for wellness programs.

Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(d) Similarly situated individuals.

The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) Participants.

Subject to paragraph (d)(3) of this section, a plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) Beneficiaries

(i) Subject to paragraph (d)(3) of this section, a plan may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

- (A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;
- (B) Relationship to the participant (for example, as a spouse or as a dependent child);
- (C) Marital status;
- (D) With respect to children of a participant, age or student status; or
- (E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) Discrimination directed at individuals.

Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any

health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) Examples.

The rules of this paragraph (d) are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's usual business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 1, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2

- (i) Facts. Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 2, treating spouses and dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3

- (i) Facts. A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 3, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4

- (i) Facts. An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination

of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

- (ii) Conclusion. In this Example 4, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5

- (i) Facts. An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee G has a different job title and different responsibilities. After G files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with G's job title receive a different benefit package that includes a lower lifetime dollar limit than in the benefit package made available to the other six employees.
- (ii) Conclusion. Under the facts of this Example 5, changing the coverage classification for G based on the existing employment classification for G is not permitted under this paragraph (d) because the creation of the new coverage classification for G is directed at G based on one or more health factors.

(e) Nonconfinement and actively-at-work provisions

(1) Nonconfinement provisions

(i) General rule.

Under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) Examples.

The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1

- (i) Facts. Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.
- (ii) Conclusion. In this Example 1, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2

- (i) Facts. In previous years, a group health plan has provided coverage through a group health insurance policy offered

by Issuer M. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer N. Under Issuer N's policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

- (ii) Conclusion. See Example 2 in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer N violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because the group health insurance coverage restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer. See Example 2 in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for the additional conclusions that under State law Issuer M may also be responsible for providing benefits to such a dependent; and that in a case in which Issuer N has an obligation under 29 CFR 2590.702(e)(1) or 45 CFR 146.121(e)(1) to provide benefits and Issuer M has an obligation under State law to provide benefits, any State laws designed to prevent more than 100% reimbursement, such as State coordination-of-benefits laws, continue to apply.

(2) Actively-at-work and continuous service provisions

(i) General rule

- (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.
- (B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1

- (i) Facts. Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.
- (ii) Conclusion. In this Example 1, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2

- (i) Facts. Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

- (ii) Conclusion. In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

(ii) Exception for the first day of work

- (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multi-employer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.
- (B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1

- (i) Facts. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual H is scheduled to begin work on August 3. However, H is unable to begin work on that day because of illness. H begins working on August 4, and H's coverage is effective on August 4.
- (ii) Conclusion. In this Example 1, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2

- (i) Facts. Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual J is scheduled to begin work on March 24. However, J is unable to begin work on March 24 because of illness. J begins working on April 7 and J's coverage is effective May 1.
- (ii) Conclusion. In this Example 2, the plan provision does not violate this section. However, as in Example 1, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) Relationship to plan provisions defining similarly situated individuals

- (i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other Federal

or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

- (ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1

- (i) Facts. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.
- (ii) Conclusion. In this Example 1, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2

- (i) Facts. To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.
- (ii) Conclusion. In this Example 2, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3

- (i) Facts. Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee B has been covered under the plan. B experiences a disabling illness that prevents B from working. B takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, B terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation.)
- (ii) Conclusion. In this Example 3, the plan provision terminating B's coverage upon B's termination of employment does not violate this section.

Example 4

- (i) Facts. Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee C is laid off for three months. When the layoff begins, C's coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)
- (ii) Conclusion. In this Example 4, the plan provision terminating C's coverage upon the cessation of C's performance of services does not violate this section.

(f) Wellness programs.

A wellness program is any program designed to promote health or prevent disease. Paragraphs (b)(2)(ii) and (c)(3) of this section provide exceptions to the general prohibitions against discrimination based on a health factor for plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this paragraph (f). If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, paragraph (f)(1) of this section clarifies that the wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of paragraph (f)(2) of this section are met.

(1) Wellness programs not subject to requirements.

If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate this section, if participation in the program is made available to all similarly situated individuals. Thus, for example, the following programs need not satisfy the requirements of paragraph (f)(2) of this section, if participation in the program is made available to all similarly situated individuals:

- (i) A program that reimburses all or part of the cost for memberships in a fitness center.
- (ii) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- (iii) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- (iv) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.
- (v) A program that provides a reward to employees for attending a monthly health education seminar.

(2) Wellness programs subject to requirements.

If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of this paragraph (f)(2) are met.

- (i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any

class of dependents (such as spouses or spouses and dependent children) may 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. For purposes of this paragraph (f)(2), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

- (ii) The program must be reasonably designed to promote health or prevent disease. 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.
- (iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.
- (iv) The reward under the program must be available to all similarly situated individuals.
 - (A) A reward is not available to all similarly situated individuals for a period unless the program allows
 - (1) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and
 - (2) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.
 - (B) 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 otherwise applicable standard.
- (v) (A) 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) required under paragraph (f)(2)(iv) of this section. However, if plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.
 - (B) The following language, or substantially similar language, can be used to satisfy the requirement of this paragraph (f)(2)(v): "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." In addition, other examples of language that would satisfy this requirement are set forth in Examples 3, 4, and 5 of paragraph (f)(3) of this section.

(3) Examples.

The rules of paragraph (f)(2) of this section are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan. The annual premium for employee-only coverage is \$3,600 (of which the employer pays \$2,700 per year and the employee pays \$900 per year). The annual premium for family coverage is \$9,000 (of which the employer pays \$4,500 per year and the employee pays \$4,500 per year). The plan offers a wellness program with an annual premium rebate of \$360. The program is available only to employees.
- (ii) Conclusion. In this Example 1, the program satisfies the requirements of paragraph (f)(2)(i) of this section because the reward for the wellness program, \$360, does not exceed 20 percent of the total annual cost of employee-only coverage, \$720. ($\$3,600 \times 20\% = \720 .) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20 percent of the cost of family coverage, \$1,800. ($\$9,000 \times 20\% = \$1,800$.)

Example 2

- (i) Facts. A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.
- (ii) Conclusion. In this Example 2, the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. (In addition, plan materials describing the program are required to disclose the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) for obtaining the premium discount. Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

Example 3

- (i) Facts. Same facts as Example 2, except that the plan provides that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count) within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200, or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount." Individual D begins a diet and exercise program but is unable to achieve a cholesterol count under 200 within the prescribed period. D's doctor determines D requires prescription medication to achieve a medically advisable cholesterol count. In addition, the doctor determines that D must be monitored through periodic blood tests to continually reevaluate D's health status. The plan accommodates D by making the discount available to D, but only if D follows the advice of D's doctor's regarding medication and blood tests.

- (ii) Conclusion. In this Example 3, the program is a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

Example 4

- (i) Facts. A group health plan will waive the \$250 annual deductible (which is less than 20 percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard) during the year is given the same discount if the individual satisfies an alternative standard that is reasonable in the burden it imposes and is reasonable taking into consideration the individual's medical situation. All plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived." Due to a medical condition, Individual E is unable to achieve a BMI of between 19 and 26 and is also unable to follow the walking program. E proposes a program based on the recommendations of E's physician. The plan agrees to make the discount available to E if E follows the physician's recommendations.
- (ii) Conclusion. In this Example 4, the program satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to walk by providing an alternative standard that is reasonable for the individual. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

Example 5

- (i) Facts. In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is 20 percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge." It is unreasonably difficult for Individual F to stop smoking cigarettes due to an addiction to nicotine (a medical condition). The plan accommodates F by requiring F to participate in a smoking cessation program to avoid the surcharge. F can avoid the surcharge for as long as F participates in the program, regardless of whether F stops smoking (as long as F continues to be addicted to nicotine).
- (ii) Conclusion. In this Example 5, the premium surcharge is permissible as a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

Example 6

- (i) Facts. Same facts as Example 5, except the plan accommodates F by requiring F to view, over a period of 12 months, a 12-hour video series on health problems associated with tobacco use. F can avoid the surcharge by complying with this requirement.
- (ii) Conclusion. In this Example 6, the requirement to watch the series of video tapes is a reasonable alternative method for avoiding the surcharge.

(g) More favorable treatment of individuals with adverse health factors permitted**(1) In rules for eligibility**

- (i) Nothing in this section prevents a group health plan from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)
- (ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 23. However, dependent children who are disabled are eligible for coverage beyond

age 23.

- (ii) Conclusion. In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2

- (i) Facts. An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees \$50 per month for employee-only coverage and \$125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee \$100 per month for employee-only coverage and \$250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)
- (ii) Conclusion. In this Example 2, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3

- (i) Facts. To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.
- (ii) Conclusion. In this Example 3, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) In premiums or contributions

- (i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health

factor, such as disability.

- (ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example

- (i) **Facts.** Under a group health plan, employees are generally required to pay \$50 per month for employee-only coverage and \$125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.
- (ii) **Conclusion.** In this Example, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) No effect on other laws.

Compliance with this section is not determinative of compliance with any provision of ERISA (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other Federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) Applicability dates.

This section applies for plan years beginning on or after July 1, 2007.

[T.D. 8931, 66 FR 1396, Jan. 8, 2001; 66 FR 14077, March 9, 2001; T.D. 9298, 71 FR 75030, Dec. 13, 2006; 72 FR 7929, Feb. 22, 2007]

26 C. F. R. § 54.9802-1, 26 CFR § 54.9802-1

Current through March 29, 2007; 72 FR 14938

**Appendix B:**

U.S. Department of Labor Employee Benefits Security Administration
Washington, D.C. 20210

FIELD ASSISTANCE BULLETIN NO. 2008-02

DATE: FEBRUARY 14, 2008

MEMORANDUM FOR: VIRGINIA C. SMITH, DIRECTOR OF ENFORCEMENT
REGIONAL DIRECTORS

FROM: DANIEL J. MAGUIRE
DIRECTOR OF HEALTH PLAN STANDARDS AND COMPLIANCE ASSISTANCE

SUBJECT: WELLNESS PROGRAM ANALYSIS

ISSUE:

What types of health promotion or disease prevention programs offered by a group health plan must comply with the Department's final wellness program regulations and how does a plan determine whether such a program is in compliance with the regulations?

BACKGROUND:

On December 13, 2006, the Departments of Labor, the Treasury, and Health and Human Services published joint final regulations on the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA). See 29 CFR 2590.702. The final regulations include guidance on the implementation of wellness programs.

HIPAA's nondiscrimination provisions generally prohibit a group health plan or group health insurance issuer from denying an individual eligibility for benefits based on a health factor and from charging an individual a higher premium than a similarly situated individual based on a health factor. Health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. An exception provides that plans may vary benefits (including cost-sharing mechanisms) and premiums or contributions based on whether an individual has met the standards of a wellness program that complies with paragraph (f) of the regulations.

The regulations apply to group health plans and group health insurance issuers on the first day of the plan year beginning on or after July 1, 2007. Accordingly, for calendar year plans, the new regulations began to apply on January 1, 2008.

Since the issuance of the final regulations, the Department has received questions concerning what types of programs must comply with the standards of 29 CFR 2590.702(f) and how to apply these standards to particular wellness programs. The following checklist provides further guidance.

WELLNESS PROGRAM CHECKLIST:

Use the following questions to help determine whether the plan offers a program of health promotion or disease prevention that is required to comply with the Department’s final wellness program regulations and, if so, whether the program is in compliance with the regulations.

A. Insert the first day of the current plan year: _____.

Is the date after July 1, 2007? Yes No

The wellness program final rules are applicable for plan years beginning on or after July 1, 2007.

B. Does the plan have a wellness program? Yes No

A wide range of wellness programs exist to promote health and prevent disease. However, these programs are not always labeled “wellness programs.” Examples include: a program that reduces individual’s cost-sharing for complying with a preventive care plan; a diagnostic testing program for health problems; and rewards for attending educational classes, following healthy lifestyle recommendations, or meeting certain biometric targets (such as weight, cholesterol, nicotine use, or blood pressure targets).

TIP: Ignore the labels – wellness programs can be called many things. Other common names include: disease management programs, smoking cessation programs, and case management programs.

C. Is the wellness program part of a group health plan? Yes No

The wellness program is only subject to Part 7 of ERISA if it is part of a group health plan. If the employer operates the wellness program as an employment policy separate from the group health plan, the program may be covered by other laws, but it is not subject to the group health plan rules discussed here.

Example: An employer institutes a policy that any employee who smokes will be fired. Here, the plan is not acting, so the wellness program rules do not apply. (*But see 29 CFR 2590.702, which clarifies that compliance with the HIPAA nondiscrimination rules, including the wellness program rules, is not determinative of compliance with any other provision of ERISA or any other State or Federal law, such as the Americans with Disabilities Act.*)

D. Does the program discriminate based on a health factor?..... Yes No

A plan discriminates based on a health factor if it requires an individual to meet a standard related to a health factor in order to obtain a reward. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

Example 1: Plan participants who have a cholesterol level under 200 will receive a premium reduction of 20%. In this Example 1, the plan requires individuals to meet a standard related to a health factor in order to obtain a reward.

Example 2: A plan requires all eligible employees to complete a health risk assessment to enroll in the plan. Employee answers are fed into a computer that identifies risk factors and sends educational information to the employee's home address. In this Example 2, the requirement to complete the assessment does not, itself, discriminate based on a health factor. However, if the plan used individuals' specific health information to discriminate in individual eligibility, benefits, or premiums, there would be discrimination based on a health factor.

If you answered "No" to **ANY** of the above questions, **STOP**. The plan does not maintain a program subject to the group health plan wellness program rules.

E. If the program discriminates based on a health factor, is the program saved by the benign discrimination provisions?..... Yes No

The Department's regulations at 29 CFR 2590.702(g) permit discrimination *in favor* of an individual based on a health factor.

Example: Plan grants participants who have diabetes a waiver of the plan's annual deductible if they enroll in a disease management program that consists of attending educational classes and following their doctor's recommendations regarding exercise and medication. *This is benign discrimination because the program is offering a reward to individuals based on an adverse health factor.*

TIP: The benign discrimination exception is **NOT** available if the plan asks diabetics to meet a standard related to a health factor (such as maintaining a certain BMI) in order to get a reward. In this case, an **intervening discrimination** is introduced and the plan cannot rely solely on the benign discrimination exception.

If you answered "Yes" to the previous question, **STOP**. There are no violations of the wellness program rules.

If you answered "No" to the previous question, the wellness program must meet the following 5 criteria.

F. Compliance Criteria

- (1) Is the amount of the reward offered under the plan limited to 20% of the applicable cost of coverage? (29 CFR 2590.702(f)(2)(i)).....** Yes No

Keep in mind these considerations when analyzing the reward amount:

Who is eligible to participate in the wellness program?

If only employees are eligible to participate, the amount of the reward must not exceed 20% of the cost of employee-only coverage under the plan. If employees and any class of dependents are eligible to participate, the reward must not exceed 20% of the cost of coverage in which an employee and any dependents are enrolled.

Does the plan have more than one wellness program?

The 20% limitation on the amount of the reward applies to all of a plan’s wellness programs *that require individuals to meet a standard related to a health factor*.

Example: If the plan has two wellness programs with standards related to a health factor, a 20% reward for meeting a body mass index target and a 10% reward for meeting a cholesterol target, it must decrease the total reward available from 30% to 20%. However, if instead, the program offered a 10% reward for meeting a body mass index target, a 10% reward for meeting a cholesterol target, and a 10% reward for completing a health risk assessment (regardless of any individual’s specific health information), the rewards do not need to be adjusted because the 10% reward for completing the health risk assessment does not require individuals to meet a standard related to a health factor.

- (2) Is the plan reasonably designed to promote health or prevent disease? (29 CFR 2590.702(f)(2)(ii))** Yes No

The program must be reasonably designed to promote health or prevent disease. The program should have a reasonable chance of improving the health of or preventing disease in participating individuals, not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease.

- (3) Are individuals who are eligible to participate given a chance to qualify at least once per year? (29 CFR 2590.702(f)(2)(iii))** Yes No

- (4) **Is the reward available to all similarly situated individuals? Does the program offer a reasonable alternative standard?**
(29 CFR 2590.702(f)(2)(iv)) Yes No

The wellness program rules require that the reward be available to all similarly situated individuals. A component of meeting this criterion is that the program must have a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period:

- o It is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; OR
- o It is medically inadvisable to attempt to satisfy the otherwise applicable standard.

It is permissible for the plan or issuer to seek verification, such as a statement from the individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

- (5) **Does the plan disclose the availability of a reasonable alternative in all plan materials describing the program?**
(29 CFR 2590.702(f)(2)(v)) Yes No

The plan or issuer must disclose the availability of a reasonable alternative standard *in all plan materials describing the program*. If plan materials merely mention that the program is available, without describing its terms, this disclosure is not required.

TIP: The disclosure does not have to say what the reasonable alternative standard is in advance. The plan can individually tailor the standard for each individual, on a case-by-case basis.

The following sample language can be used 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, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward."

If you answered “Yes” to **ALL** of the 5 questions on wellness program criteria, there are no violations of the HIPAA wellness program rules.

If you answered “No” to **any** of the 5 questions on wellness program criteria, the plan has a wellness program compliance issue. Specifically,

Violation of the general benefit discrimination rule (29 CFR 2590.702(b)(2)(i)) – If the wellness program varies benefits, including cost-sharing mechanisms (such as deductible, copayment, or coinsurance) based on whether an individual meets a standard related to a health factor and the program does not satisfy the requirements of 29 CFR 2590.702(f), the plan is impermissibly discriminating in benefits based on a health factor. The wellness program exception at 29 CFR 2590.702(b)(2)(ii) is not satisfied and the plan is in violation of 29 CFR 2590.702(b)(2)(i).

Violation of general premium discrimination rule (29 CFR 2590.702(c)(1)) – If the wellness program varies the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual meets a standard related to a health factor and the program does not satisfy the requirements of 29 CFR 2590.702(f), the plan is impermissibly discriminating in premiums based on a health factor. The wellness program exception at 29 CFR 2590.702(c)(3) is not satisfied and the plan is in violation of 29 CFR 2590.702(c)(1).

Additional compliance information regarding the other provisions in Part 7 of ERISA, including the HIPAA portability provisions and the rest of the HIPAA nondiscrimination provisions, is available on the Department’s website at: <http://www.dol.gov/ebsa/pdf/CAGAppA.pdf>.

Questions concerning the information contained in this Bulletin may be directed to the Office of Health Plan Standards and Compliance Assistance at 202-693-8335.

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