June 19, 2015

Ms. Bernadette B. Wilson, Acting Executive Officer
Executive Secretariat
Equal Employment Opportunity Commission
131 M Street NE
Washington, DC 20507

Re: RIN 3046-AB01; Amendments to Regulations under the Americans with Disabilities Act; Proposed Rule

Dear Ms. Wilson:

We are pleased to submit these comments on behalf of the College and University Professional Association for Human Resources, the International Public Management Association for Human Resources, the National Public Employer Labor Relations Association, the Associated Builders and Contractors, the National Retail Federation, and the Retail Industry Leaders Association in response to the Equal Employment Opportunity Commission's (EEOC's or Commission's) proposed amendments to the regulations implementing Title I of the Americans with Disabilities Act (ADA) as published in the *Federal Register* on April 20, 2015.[1] The proposal addresses the use of employer wellness programs and the extent to which the use of incentives in conjunction with such programs may violate the ADA.

Summary of Comments

We are pleased that the Commission has confirmed that it is seeking to revise its regulations under the ADA in a manner that comports with the Affordable Care Act (ACA) and regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) by the Department of Labor, Department of Treasury, and Department of Health and Human Services (the tri-agency regulation).[2] However, we have several significant concerns with the Commission's proposed amendments. In these comments, we address the proposal's inappropriate treatment of the ADA's insurance safe harbor and urge the Commission to adopt incentive limits and reasonable design standards consistent with existing tri-agency regulations.

In addition, these comments urge the Commission to address participation in wellness plans by dependents of employees and the measure of any incentives used in such plans similar to that used in the tri-agency regulations. We also urge the Commission to refrain from adopting

[1] 75 Fed. Reg. 21,659.
[2] Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, Final Rule, 78 Fed. Reg. 33,158 (June 3, 2013).

a new notice or affordability standard. Additional matters addressed include clarifying the reasonable accommodation duty, potential interaction with GINA, and the need for a significant amount of time for employers to come into compliance with any new requirements.

Statement of Interest

The **College and University Professional Association for Human Resources** (CUPA-HR) serves as the voice of human resources in higher education, representing more than 18,000 human resources professionals and other campus leaders at over 1,900 colleges and universities across the country, including 91 percent of all United States doctoral institutions, 77 percent of all master's institutions, 57 percent of all bachelor's institutions, and 600 two-year and specialized institutions. Higher education employs over 3.7 million workers nationwide, with colleges and universities in all 50 states.

The **International Public Management Association for Human Resources** (IPMA-HR) represents public sector human resource professionals and human resource departments. Since 1906, IPMA-HR has enhanced public sector human resource management excellence through research, publications, professional development and conferences, certification, assessment and advocacy.

The **National Public Employer Labor Relations Association** (NPELRA), a not-for-profit corporation established in 1970, represents public sector and not-for-profit entities and practitioners of labor and employee relations employed therein. NPELRA and its members function as fiduciaries to the interests of the citizens, in part, by advocating the development of sound local, state and national policy relative to hiring, compensation, benefits, and employee/labor management relations.

Associated Builders and Contractors (ABC) is a national construction industry trade association with 22,000 chapter members. ABC and its 70 chapters help members develop people, win work and deliver that work safely, ethically and profitably for the betterment of the communities in which they work. ABC member contractors employ workers, whose training and experience span all of the 20-plus skilled trades that comprise the construction industry. Moreover, the vast majority of our contractor members are classified as small businesses. Our diverse membership is bound by a shared commitment to the merit shop philosophy in the construction industry. The philosophy is based on the principles of nondiscrimination due to labor affiliation and the awarding of construction contracts through open, competitive bidding based on safety, quality and value. This process assures that taxpayers and consumers will receive the most for their construction dollar.

The **National Retail Federation** (NRF) is the world's largest retail trade association, representing discount and department stores, home goods and specialty stores, Main Street merchants, grocers, wholesalers, chain restaurants and Internet retailers from the United States and more than 45 countries. Retail is the nation's largest private sector employer, supporting one in four U.S. jobs – 42 million working Americans. Contributing $2.6 trillion to annual GDP, retail is a daily barometer for the nation's economy.

Retail Industry Leaders Association (RILA), the trade association of the world's largest and most innovative retail companies, product manufacturers, and service suppliers, promotes consumer choice and economic freedom through public policy and industry operational excellence. RILA's members provide millions of jobs and operate more than 100,000 stores, manufacturing facilities and distribution centers domestically and abroad.

The ADA, the ACA, and Wellness Plans

Section 102(d)(4) of the ADA, codified at 42 U.S.C. Section 12112(d)(4) addresses medical examinations and inquiries of employees. The Commission's proposal focuses in particular on Section 102(d)(4)(B), which describes acceptable examinations and inquiries as including "voluntary medical examinations, including voluntary medical histories, which are part of an employee health program … ."

In its proposal, the Commission observes that its interpretation of the term "'voluntary' is central to the interaction between the ADA and HIPAA's wellness program provisions, as amended by the Affordable Care Act." The Commission further observes that a "plausible reading of 'voluntary' in isolation is that covered entities can only offer de minimis rewards or penalties to employees for their participation (or nonparticipation) in wellness programs that include disability-related inquiries and medical examinations." However, recognizing that such an interpretation would make many wellness programs expressly permitted by HIPAA unlawful under the ADA, the Commission's proposal concludes that the agency "has a responsibility to interpret the ADA in a manner that reflects both the ADA's goal of limiting employer access to medical information and HIPAA's and the Affordable Care Act's provisions promoting wellness programs."

We agree that the Commission has a responsibility to interpret the ADA consistent with the ACA and the tri-agency wellness regulations. When Congress enacted the ACA, it was mindful of a regulatory regime established in 2006 by the Departments of Labor, Treasury, and Health and Human Services that, among other things, regulated the use of incentives in wellness programs. In the ACA, Congress generally endorsed the tri-agency regulatory framework that had been established, including different treatment of participatory wellness programs and health-contingent wellness programs. For example, incentive limits were only applicable to

health-contingent wellness programs, not to participatory wellness plans. While retaining this framework, Congress significantly expanded the extent to which wellness plans could use rewards, including both incentives and penalties, to encourage participation.

The legislative compromise that led to this expansion was made after the Senate Health, Education, Labor, and Pensions (HELP) Committee heard significant testimony about the success of existing wellness programs and how further use of incentives could play an important role in health care reform.[3] In response, the HELP Committee approved, on a bipartisan basis, an amendment to increase the incentive limit from 20 percent of the total cost of health care coverage to 30 percent. The Committee also empowered the three agencies to increase the incentive limit to as high as 50 percent if they determine such an increase "is appropriate." This compromise survived the legislative process and has been codified into law.[4]

Importantly, at the time Congress was considering the ACA, the EEOC had not taken any steps to challenge employer wellness programs based on the use of incentives.[5]

While we appreciate the Commission's goal of implementing regulations under the ADA that are consistent with the ACA's goal of promoting wellness programs, the proposal fails to do so in a number of important areas, which we discuss below.

Proposal Improperly Characterizes Insurance Safe Harbor

Among the most controversial aspects of the Commission's proposal is treatment of the ADA's insurance safe harbor with respect to employer wellness programs. The insurance safe harbor was enacted as section 501(c) of the ADA and is codified at 42 U.S.C. Section 12201(c). It states that the ADA shall not be construed to prohibit or restrict:

> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
> (2) a [covered entity] from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

[3] See, for example, Healthcare Reform Roundtable (Part I), Hearing of the Committee on Health, Education, Labor, and Pensions, United States Senate, S. Hrg. 111-974 (June 11, 2009)
[4] See 42 U.S.C. § 300gg-4(j)(3)(A).
[5] The EEOC first challenged a wellness program under the ADA in 2014. See Press Release, EEOC Lawsuit Challenges Orion Energy Wellness Program and Related Firing of Employee (Aug. 20, 2014), available at: http://www.eeoc.gov/eeoc/newsroom/release/8-20-14.cfm.

(3) a [covered entity] from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

The ADA, as enacted, granted the EEOC the authority to issue regulations interpreting Title I of the ADA. The ADA Amendments Act of 2008 expanded this regulatory authority to cover definitions included in Sections 3 and 4 of the ADA.[6] However, Congress has not granted the EEOC any authority to issue regulations under Section 501(c).

Nevertheless, the proposal's preamble includes a footnote stating that the Commission does not believe that the insurance safe harbor is the proper basis for evaluating wellness program incentives. As noted in the footnote, this is contrary to the interpretation of the Eleventh Circuit in *Seff v. Broward County*,[7] the one Circuit Court of Appeals case addressing the issue. In *Seff*, the Eleventh Circuit upheld a ruling rejecting a claim that a public sector employer's wellness program operated contrary to the ADA's medical examinations and inquiries provisions. In doing so, the court found that the wellness plan fell under the insurance safe harbor provision because it was a term of the employer's group health insurance plan.

Disagreeing with this interpretation, the Commission instead states that wellness programs are to be considered under the "'clear' safe harbor" codified at 42 U.S.C. section 12112(d)(4)(B). According to the Commission, reading the insurance safe harbor as exempting wellness programs from coverage would "render the 'voluntary' provision superfluous."

This is an interesting assertion by the Commission because the legislative history of the ADA indicates that the "'clear' safe harbor" may indeed be superfluous. The current language codified as section 12112(d)(4)(B) is the result of an amendment made during consideration of the bill by the House Judiciary Committee at the same time the Committee amended the immediate prior provision, section 12112(d)(4)(A) related to prohibited examinations and inquiries. Prior to consideration by the Committee, two provisions read as follows:

(4) Examination and Inquiry.

(A) Prohibited Examinations and Inquiries.—A covered entity shall not conduct or require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.

[6] See 42 U.S.C. §§ 12116, 12210.
[7] 691 F.3d 1221 (11th Cir. 2012).

(B) Acceptable Inquiries.—A covered entity may make inquiries into the ability of an employee to perform job-related functions.[8]

During consideration by the House Judiciary Committee, these provisions were changed. In subparagraph (4)(A), the words "conduct or require" were changed to "require." In addition, the following sentence was added to the beginning of subparagraph 4(B): "A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."

While there is scant legislative history describing the reasoning behind the amendments, a law review article published shortly after enactment of the ADA described the amendments as being necessary because subparagraph 4(A) could be read to require that every medical examination be job-validated, even if the examination was voluntary. According to the article, it was never the intent of ADA proponents to prohibit voluntary medical examinations, and consequently an agreement was reached to delete the word "conduct" from the paragraph. As further described in the article, some members of the business community "wanted additional language stating that voluntary medical examinations were permissible. Although disability advocates felt that such an additional provision was superfluous, the provision regarding voluntary examinations was added because it was consistent with the agreed upon policy approach."[9] The article was authored by a leader in the effort to enact the ADA, EEOC Commissioner Feldblum.

In other words, there is compelling evidence Congress did not intend that ADA regulation of wellness programs would be addressed solely by the first sentence of subparagraph 4(B) as the Commission now claims.

In addition to these matters of statutory interpretation, the Commission's assertion is incorrect. The insurance safe harbor does not overlap with Subparagraph 4(B) with respect to wellness programs outside of employer-provided insurance. At the time the ADA was enacted, many wellness programs utilized incentives but were not part of employer insurance programs. Examples include providing workout facilities for employees, cost-sharing to attend nutritional counseling classes, weight-loss competitions, providing financial support for smoking cessation programs, bonuses for employees who quit smoking, financial incentives to all non-smokers among others.[10] Such programs could not be regulated under the insurance safe harbor if they

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[8] See, for example, U.S. House of Representatives, Committee on Education and Labor, Legislative History of Public Law 101-336, the Americans with Disabilities Act, 101st Cong, 2d Sess. (Dec. 1990) at 278 (reprinting House Report 101-485, part 2, the House Education and Workforce Committee's report on H.R. 2273).

[9] Chai R. Feldblum, Medical Examinations and Inquiries under the Americans with Disabilities Act: A View from the Inside, 64 Temp. L. Rev. 521, 540 (1991)(emphasis added).

[10] See, for example, Gary F. Knadler et al., Physical Fitness Programs in the Workplace, Washington Business Group on Health (1987); Karen Glanz, Nutrition Programs in the Workplace, Washington Business Group on Health (1986); Ruth A. Behrens, Reducing Smoking at the Workplace, Washington Business Group on Health (1985).

were not part of an insurance program and might be more properly analyzed under the medical examinations and inquiries paragraphs cited above.

While the Commission's proposal focuses exclusively on wellness programs that operate as part of a group health plan, it should be emphasized that many employers provide wellness programs that operate outside of a group health plan or apply to employees or dependents regardless of whether they have insurance through the employer.

Permissible Incentive Limits Should Mirror Those Allowed Under the Tri-Agency Regulations

The Commission's proposal establishes a limit for incentives used in conjunction with wellness programs at the rate of 30 percent of the total cost of employee-only coverage. According to the proposal's preamble, this limit was established to comport with the standard set under the ACA and tri-agency regulations while ensuring that incentive limits are not so high as to make participation in programs involuntary.

However, the Commission's proposed incentive limits depart from those expressly allowed under the tri-agency regulations in several important ways, most notably by including within the incentive limit a broader scope of wellness programs and by refusing to permit higher incentives for programs designed to prevent or reduce tobacco use.

Under the tri-agency regulations, participatory wellness programs are programs that are made available to all similarly situated individuals and that do not either provide a reward or do not include any conditions for obtaining a reward that are based on an individual satisfying a standard related to a health factor. Examples of participatory wellness programs include an employer subsidizing the cost of gym membership for all employees or an employer that provides an incentive to all employees who complete a health risk assessment regardless of any health issues identified.

In contrast, health-contingent wellness programs require employees to satisfy a standard related to a health factor to obtain a reward. According to the Preamble accompanying the tri-agency regulations, most wellness programs are participatory. Under the tri-agency regulations, there is no incentive limit for such programs because the availability of the program to all similarly situated individuals, regardless of health status, ensures that the general prohibition against discrimination based on a health factor is not implicated.[11]

Instead of following the tri-agency approach, the EEOC's proposal would count incentives from both participatory wellness programs and health contingent wellness toward the

[11] 78 Fed. Reg. at 33,161.

30-percent limit. Plans would only be exempt from the requirement if they contained no medical examinations or disability-related inquiries.

With respect to tobacco cessation programs, the ACA and the tri-agency regulations permit wellness programs to utilize incentives up to 50 percent as authorized by Congress. However, the Commission's proposal caps all incentives at 30 percent. The Commission's proposal, consistent with the ADA, do not apply if there is no medical examination or inquiry. In other words, an employer could provide a 50 percent penalty on smokers if it simply asked them if they smoke, as such a question is not a medical examination or inquiry. However, if an employer chose to test for cotinine (a nicotine derivative) presence, the maximum penalty it could impose would be 30 percent of the total cost of employee-only coverage. The proposal does not explain the basis for disallowing an incentive of up to 50 percent for smoking cessation programs and nothing in the ADA compels the EEOC to reach such a result.

We strongly recommend that the Commission's regulations truly comport with the tri-agency standards by expressly recognizing that those standards satisfy the ADA's requirements. In addition, the Commission's proposed addition of Sections 1630.14(d)(2)(i) and (iii) are not controversial and would serve to ensure that wellness programs meet the statutory standard.

Instead, the Commission has proposed new standards that will apply to the majority of wellness programs that today are not covered by any incentive limit. Employers who choose to offer wellness programs with incentives will now need to track incentive amounts falling into four separate categories:

(1) participatory wellness programs without medical examinations or inquiries;
(2) participatory wellness programs with medical examinations or inquiries;
(3) health-contingent wellness programs without medical examinations or inquiries; and
(4) health-contingent wellness programs with medical examinations or inquiries.

The Commission does not attempt to quantify the burden that this new scheme will impose on employers, simply asserting that a majority of employers currently do not offer incentives above 30 percent of premiums. In order to determine whether the impact that the proposed scheme could have on employers, the Commission should first conduct a more thorough economic analysis to determine the costs associated with such a significant change in program management and the extent to which employers will be less likely to offer participatory wellness programs if this proposed provision is adopted.

The Proposed Regulation Impermissibly Seeks To Regulate Health Program Design

Proposed section 1630.14(d)(1) sets forth a requirement that any "employee health program" must be "reasonably designed to promote health or prevent disease." The proposal further states that:

> A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating employees, and it is not overly burdensome, is not a subterfuge for violating the ADA or other laws prohibiting employment discrimination, and is not highly suspect in the method chosen to promote health or prevent disease.

In the proposal's Preamble, the Commission states that the standard is similar to that codified in the tri-agency regulations.

Employers are generally comfortable with the reasonable design requirement that was enacted as part of the ACA and implemented in the tri-agency regulations. However, they have significant concerns with the Commission's use of a new reasonable design standard that may not be consistent with current regulations. Employers are also concerned that the Commission could interpret its new standard inconsistent with the tri-agency standards for reasonable design enforced by the Departments of Labor, Treasury, and Health and Human Services.

The ACA makes clear that the purpose of the reasonableness determination is not prescriptive. This was emphasized during the rulemaking process that led to the current tri-agency regulations, as the agencies stated that while the standard was drafted to prevent abuse, it was otherwise designed to be easy to satisfy in order to allow experimentation in diverse ways of promoting wellness.[12]

However, the proposal includes new provisions that raise questions about whether the Commission intends to follow a permissive approach and indicates that the EEOC may be intending a new, narrower standard of reasonable design. For example, the proposed interpretive guidance states that "collecting medical information on a health questionnaire without providing employees follow-up information or advice, such as providing feedback about health risk factors or using aggregate information to design programs or treat any specific conditions, would not be reasonably designed to promote health."

Such a fact pattern is unlikely, but even if it did occur it is hard to see how the EEOC could condemn all such instances as discriminatory under the ADA. Imagine, for example, an employer that has maintained a wellness plan that asks participants to complete a Health Risk Assessment (HRA). The employer has used the program for several years and uses aggregate information from the HRAs to design health programs or make adjustments in existing programs.

[12] See Public Health Service Act, 42 U.S.C. § 2705(j)(3)(B) and 77 Fed. Reg. 70,619, 70,625 (Nov. 26, 2012).

If such an employer decides mid-way through its plan year to abandon its current wellness plan and develop a new plan, the old plan will fail the Commission's reasonable design test if the data for the most recent year are not, in fact, used. Should the decision to abandon a plan part way through the year be enough to fail the Commission's reasonable design standard when such conduct would not run afoul of the standard used in the tri-agency regulation?

We do not believe it is necessary for the Commission to include a reasonable design standard as part of its ADA regulations and we recommend that the Commission remove this provision from its final rules. If, however, the Commission decides to retain a reasonable design standard, it should make it clear that the standard is the same as that used under the tri-agency regulations.

If the Commission includes a section on reasonable design in its interpretative guidance, it should clarify that the examples of medical examinations and inquiries discussed, and the purposes for which they are used, are illustrative only. There are a number of other legitimate purposes for which a wellness program might utilize a health risk assessment, for example, including helping focus an employee's attention on a known health problem or as a measure of progress in addressing that problem. In addition, while an employer may review aggregate health information obtained through a wellness program with program design in mind, there may be any number of reasons why the employer chooses not to make modifications to its program from year to year. The current proposed interpretative guidance could be read to imply that an employer's decision to keep a current program in place is somehow not reasonably designed.

Proposal Does Not Address Coverage of Dependents

Incentives for spouses and other dependents are a common feature for many employer wellness programs. The tri-agency regulations recognize this and where spouse or dependent incentives are utilized, measure the size of incentive against the total cost of coverage in which the employee and dependents are enrolled.

The proposal does not address wellness plans that cover spouses or dependents in any way. In addition, the incentive limit is linked directly to the cost of employee-only coverage, but the proposal does not discuss how the incentive limit might apply if an employee has health care coverage for a spouse or one or more additional dependents. There is no reason why the EEOC could not adopt the same standard for determining voluntariness.

EEOC Should Not Adopt an Affordability Requirement

In the preamble to its proposal, the Commission invites comment on whether an incentive should be deemed coercive and unlawful if it is "so large as to render health insurance coverage

unaffordable under the Affordable Care Act." The Commission states that the cost of health insurance is generally considered affordable if the portion that an employee would be required to pay for employee-only coverage does not exceed 9.56 percent of household income.

Affordability of health care is a matter properly addressed by health care law and regulation, not through the section of the ADA addressing medical examination or inquiries. The ACA creates incentives for employers to offer employees health care coverage. However, it does not require coverage. In addition, the ACA does not require that every health plan offered by an employer meet the ACA's definition of "affordable." Very generally speaking, if an employer offers one plan that meets the ACA's definition of affordable, then its obligations are met.

It appears that the Commission is considering a proposal to import the ACA's affordability test and apply it to all employer health plans, a significant interference with the scheme by which such plans are regulated and could create a significant disincentive for employers to offer more robust health care plans. The Commission should refrain from adding an "affordability" test to its regulations.

The Commission Should Not Mandate Full Incentive Payments Based on Medical Certification

The proposal states that the Commission invites comments on whether individuals should be eligible to receive a full incentive, even if they decline to participate in a wellness program, if a medical professional certifies that the employee is under a physician's care and any medical risks are under active treatment.

Standards adopted under the tri-agency regulations require that employers either waive requirements to receive an incentive or make a reasonable alternative standard available for employees for whom it is unreasonably difficult to satisfy the standard due to a medical condition or for employees for whom it is medically inadvisable to attempt to satisfy the standard. This framework is sufficient to ensure that individuals can earn the full amount of incentive even if an impairment makes it more difficult to meet the requirements of a health contingent wellness program.

The ADA Should Not Eliminate "Gateway" Plans

Proposed Section 1630.14(d)(2)(ii) states that voluntary plans may not:

> Deny coverage under any of its group health plans or particular benefits packages within a group health plan for non-participation, or limit the extent of benefits … for employees who do not participate.

Under the ACA and tri-agency regulations, an employer may offer different benefit options under its health plan, including options that are only available to those who choose to participate in a wellness program. As discussed above, the tri-agency regulations provide sufficient standards to ensure all employees are able to participate in a wellness plan and obtain an incentive or avoid a penalty. Gateway plans are an important option utilized by many employers in controlling health care costs and offer improved benefits. They are an important part of the market for health care services that the EEOC should not now attempt to eliminate.

Notice Requirement Largely Duplicative of Current Law

Under the proposal, wellness plans that are part of group health plans would be required to issue a notice to participants. The notice would be required to ensure that employees understand the type of medical information that will be obtained and the purposes for which it will be used. The proposed notice would also address restrictions on disclosure of the employee's medical information.

We question the need to mandate a new employee notice in order to satisfy the requirement that the program be voluntary. Existing incentive limits should be adequate to ensure participation is voluntary.

Further, with respect to wellness programs that are part of group health plans, HIPAA regulations already establish requirements for covered entities to notify participants about privacy practices and strictly regulate how personally identifiable information will be used. This is recognized by the Commission in the supporting statement that it submitted to the Office of Management and Budget with respect to the proposed notice requirement. In that statement, the EEOC states that "we assume that some employers and group health plans may already have notices created for other purposes that would satisfy the … requirements in the EEOC's proposed rule." Other laws may also provide overlapping notice requirements, such as the Employee Retirement Income Security Act's (ERISA) required summary plan descriptions.

While we do not support the addition of a new notice requirement, if the Commission decides to include a notice requirement in the final rule, then it should state that compliance with HIPAA privacy regulations is sufficient for compliance under the ADA.

Any Notice Requirement Should Be Waived Where Incentives Are Only De Minimis

The Commission has requested comments on whether its proposed notice requirement should be waived if incentives are only de minimis.

If there is to be a notice requirement, the Commission should waive the notice requirement if incentives are only de minimis. If incentives are de minimis, such as the cost of a t-shirt, coffee mug, or a gift card for coffee or a meal, then the size of incentives will simply not be coercive under any circumstance. Waiving the notice requirement in such cases will ease compliance burdens.

The ADA Does Not Require Prior, Written, and Knowing Confirmation That Participation is Voluntary

The EEOC has invited comments on whether employers should be required to obtain prior, written, knowing confirmation that participation in a wellness program that includes disability-related inquiries or medical examinations is voluntary.

While prior, written, or knowing confirmation may be *evidence* of voluntariness, the ADA does not establish any such requirements in order for a medical examination or disability-related inquiry to be voluntary. This request for comments appears based on a provision of GINA that permits employers to request or require employee genetic information where an employer offers health or genetic services. One element of that provision requires that the employee provide prior, knowing, voluntary, and written authorization in order to invoke the exception.[13]

The interaction between GINA and the ADA are important with respect to employer wellness programs. Questions such as this present compelling evidence that the two rulemakings should occur in parallel with stakeholders able to comment on both proposals simultaneously. However, the instant rulemaking is about voluntariness under the ADA, not GINA. The Commission should refrain from including such a requirement in its final rule.

Clarification Needed for Reasonable Accommodation Requirements

The proposed revision to the interpretive guidance describes how wellness programs must offer reasonable accommodations to employees with disabilities, absent undue hardship. The proposal is broader than the tri-agency regulations because it applies to both participatory and health-contingent wellness programs while the tri-agency requirement only applies its reasonable alternative standard to health contingent wellness programs. In the Commission's proposed interpretive guidance, the Commission notes that providing a reasonable alternative standard along with notice to employees that a reasonable alternative standard is available "would likely fulfill a covered entity's obligation to provide a reasonable accommodation under the ADA."

[13] 42 U.S.C. § 2000ff-1(b)(2)(B).

We are supportive of the Commission's assurance that compliance with the tri-agency regulations' requirement to provide a reasonable alternative standard will likely comply with the obligation to provide reasonable accommodations under the ADA. However, by use of the term "likely," the Commission is implying that there may be some practices in compliance with the reasonable alternative standard requirement of the tri-agency regulations that do not meet the ADA's standards. The Commission should offer an example or state more definitively that compliance with the reasonable alternative standard will be compliant with the ADA.

In addition, we are concerned that the Commission's proposed interpretive guidance may confuse an employer's duty to provide a reasonable accommodation under Title I of the ADA with the duty of a provider of public accommodations to provide auxiliary aids and services under Title III of the ADA, which is outside of EEOC's jurisdiction. For example, if an employer's participatory wellness plan provides reimbursement for the cost of a gym membership or the cost of attending a particular health class, the provider of such services would be obligated to comply with Title III's requirements and may need to provide auxiliary aids and services. However, that is quite distinct from an employer's obligations under Title I.

Wellness Programs Outside of Group Health Plans

The proposal appears to be drafted as if all wellness programs were part of group health plans, but invites comment on the extent to which employers offer (or are likely to offer in the future) wellness programs outside of a group health plan that utilize incentives and the extent to which ADA regulations should limit incentives.

There are a wide variety of wellness plans that operate outside of an employer's group health plan. For example, an employer may host health screenings for employees or provide vaccination services. Similarly, subsidized gym memberships (or even an on-site gym) are commonly available outside of group health plans. Many employers also offer access to weight loss, diabetes control, nutritional/healthy eating, and smoking cessation programs outside of health plans. In addition, some employers provide free access to healthy beverages and snacks while others, particularly in the retail sector, report offering store discounts on healthy foods. Retail employers also report utilizing store gift card incentives for enrolling and participating in wellness programs offered outside of group health plans.

Proposal Fails to Address GINA

The EEOC has proposed its revisions to its ADA regulations in a vacuum, even though it had long planned to release regulations under both the ADA and the Genetic Information Nondiscrimination Act (GINA) concurrently. In fashioning a response to the current rulemaking, the public is not able to take into account how the Commission plans to address wellness plans

under GINA. The Commission might receive more helpful comments after members of the public have had the opportunity to consider both proposals together. We urge the Commission to keep an open mind about re-opening the public comment period after the GINA proposal is published to ensure the final regulation accounts for the views of stakeholders formed after considering both proposals together.

Effective Date of Final Regulations

The proposal does not identify how long a time period EEOC plans to provide between finalization of the rules and the date that employers must come into compliance. We urge the Commission to consider that its regulations may necessitate significant changes in plan design. Significant lead time is necessary to implement changes in plans, including designing new systems and creating and printing materials in advance of a new plan year. Accordingly, the Commission should consider either a significant delay before the effective date or a phased-in effective date, requiring compliance with the start of a new plan year after an appropriate period of time, such as one year, to allow for revision of plans and system updates.

Thank you for your consideration of these comments. Please do not hesitate to contact us if we may be of further assistance as the Commission proceeds to consider these important issues.

Sincerely,

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