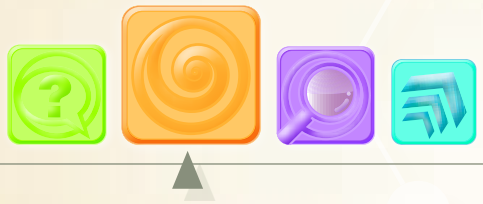

Voluntary Means Voluntary? AARP Prevails in Challenge to EEOC's Interpretation of Voluntary and How Plans Should Respond

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A December 2018 court ruling dealt many incentivized wellness programs a serious blow. This comes as wellness programs continue to lose some of their luster for many plan sponsors. The ruling itself is generally summed up as a condemnation of the Equal Employment Opportunity Commission's (EEOC's) definition of voluntary resulting in a grey area around wellness incentives and penalties related to the collection of health and generic information. Certainly, a response depends on the plan's philosophical stance on wellness. The following summary briefly recaps the ruling, its background and rationale and briefly explores potential plan responses.

The Law - HIPAA

As most readers are likely aware, the Affordable Care Act (ACA) included changes to the Health Insurance Portability and Accountability Act (HIPAA) wellness regulations. The ACA categorizes wellness programs as either participatory or health contingent depending on the program's standards for receiving a reward. While all programs are generally prohibited from discriminating against plan participants based on a health factor, a program's classification dictates the size of the reward a plan sponsor may make available to the plan participant and if it must offer a reasonable alternative standard (RAS).

Under a participatory program, such as incentivizing a participant's completion of a health risk assessment or reimbursement for a gym membership, the reward is not contingent upon satisfaction of a standard related to a health factor. Unlike participatory programs, health-contingent programs are strictly regulated by the ACA because under these programs the reward is contingent upon a participant satisfying a standard related to a health factor. Generally, health-contingent offerings must provide an RAS, and plan participants must be given an opportunity to qualify for the reward at least once every year. Thus, under the HIPAA wellness program regulations, as amended and promulgated by the ACA, the size of the reward is limited to 30 percent of the total cost of coverage under such programs, but programs that involve an outcome-based tobacco cessation component may increase the total reward to 50 percent of the total cost of coverage.

The Intersection with ADA and GINA

In 2014, the EEOC filed lawsuits against three plan sponsors claiming that each plan sponsors' wellness programs violated the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). In its claims, the EEOC questioned the voluntariness of the program under the ADA and GINA. While some of the programs that the EEOC challenged did not even align with the HIPAA regulations, the courts resoundingly criticized the EEOC for enforcing these claims prior to issuing any guidance regarding these programs.

EEOC Rules

In response to this criticism, the EEOC released final rules May 16, 2016 regarding financial incentives becoming effective for plans beginning on, or after, January 1, 2017. Despite many organizations advocating that the EEOC mirror its wellness regulations after the HIPAA wellness program regulations, as amended by the ACA, the EEOC declined to fully accommodate such requests. Unlike the HIPAA rules, the ADA and GINA rules apply regardless of whether the program is considered a participatory or health-contingent program under the HIPAA standards. Thus, although HIPAA does not impose an incentive limit on programs that do not require the individual to satisfy a standard related to a health factor, the ADA and GINA rules will impose a limit on the incentive/penalty for these programs if the requirements of such programs fall within the regulatory jurisdiction of the ADA or GINA, specifically medical or disability related inquires or genetic related inquiries.

According to this 2016 final rule, if participation in a wellness program is contingent upon enrollment in a group's health plan, the employee may receive an incentive of up to 30 percent of the total cost of self-only coverage under that plan. If an employer does not offer a group health plan, the incentive is limited to 30 percent of the total cost of the second-lowest cost Silver Plan for a 40-year-old non-smoker available through the state or federal exchange in the location that the employer identifies as its principle place of business.

Contrary to HIPAA's 50 percent incentive limit for programs with a tobacco cessation component, the ADA limits the incentive to 30 percent if the program uses a biometric screening or other medical procedure to test for the presence of nicotine or tobacco. However, plans that simply ask participants whether they use tobacco products are not subject to the ADA and such incentive limits would not apply.

Paralleling the ADA's incentive limitations, the GINA final rule allows plans to offer an incentive of 30 percent of the cost of self-only coverage for a spouse's provision of medical information through a Health Reimbursement Account (HRA). Thus, the total incentive that may be offered with such programs will be no more than 30 percent of the total cost for self-only coverage multiplied by two. The GINA rules mirror the ADA's method for determining which self-only plan will be used as the benchmark for determining the amount of the incentive discussed above.

AARP vs. EEOC Challenge

American Association of Retired Persons (AARP) filed its complaint in October 2016 questioning the EEOC's issued regulations. On behalf of its members, it asserted that EEOC issued regulations under the ADA and GINA that allow employers to impose heavy financial penalties on employees who do not participate in employee wellness programs. According to the AARP, because most wellness programs involve the collection of medical information through detailed medical questionnaires and biometric testing, the issued regulations enable employers to penalize employees substantially for choosing not to divulge medical or genetic information about themselves or their families in the workplace. Specifically, AARP argued that the 30 percent incentive permitted by the new rules are inconsistent with the "voluntary" requirements of the ADA and GINA, and that employees who cannot afford to pay a 30 percent increase in premiums will be forced to disclose their protected information when they otherwise would choose not to do so.

The EEOC responded by challenging the AARP's standing and asserting that its determination of "voluntary" was correct and permitted. Relative to its interpretation of "voluntary," the EEOC argued that the new rules survive the deferential standard of review afforded agency decisions in Administrative Procedure Act cases.

August 2017 Opinion

The U.S. Federal District Court for the District of Columbia, delivered its opinion in August 2017. The court found that the AARP had associational standing to challenge both the ADA rule and the GINA rule on behalf of its members. The court then turned to examine the EEOC's "voluntary" standard. The court reiterated that while an administrative agency is typically given deference in its interpretation of a statute, in order to receive this deference, the agency's chosen interpretation must be reasonable and must be supported by the administrative record. The court concluded that the EEOC had not provided a reasoned explanation for its interpretation. It noted that the EEOC determined that incentives greater than 30 percent of the cost of coverage would render the disclosure of protected medical information pursuant to a wellness program "involuntary" under the ADA, but an incentive of 30 percent or less would not. It viewed this reasoning to not have a firm logical basis.

One can see that the EEOC was seemingly tying to harmonize the HIPAA wellness regulations and the ADA/GINA regulations. However, the court did not see this as a reasonable approach. The court cited such an effort by the EEOC as evidence of the unreasonableness of this tactic. The court noted that the statutes (HIPAA vs. ADA/GINA) seek to regulate two very different topics. HIPAA's rules seek to regulate insurance discrimination and the ADA rule regulates disclosure of health information. The court noted that HIPAA doesn't offer a simple 30 percent cap; such a cap is only applicable to outcomes based programs– there is no cap for participatory programs. While handled separately in the opinion, GINA issued regulations suffered from the same challenges that the 30 percent threshold failed to meet the "reasonableness" standard under the ADA.

Having found that both the ADA rule and the GINA rule are arbitrary and capricious, the court then turned to identify the appropriate remedy. According to the court, an agency's failure to provide a reasoned explanation for its decision requires a court to remand to the agency for further consideration, but does not necessarily require the rules be vacated. Citing the significant disruptive conse-

quences, the court in this case did not vacate the rules and simply remanded the rules to the agency for reconsideration. That said, this ruling was based on the assumption that the agency could address the rules' failings in a timely manner.

December 2017 Opinion

Following the August ruling, the AARP became aware of the EEOC's proposed timeline to correct the rules and filed a motion with the court questioning the reasonableness of the EEOC's timeline and again sought the 30 percent definition be vacated. In response to this motion to amend the August 2017 opinion, the court granted the AARP's motion and required that the current EEOC issued regulation be vacated January 1, 2019. Moreover, the court ordered the EEOC to file a status report by no later than March 30, 2018 informing the court of the EEOC's schedule for reviewing its rules and any further administrative proceedings.

While the AARP presented several arguments supporting vacating the regulations, the court pointed to the EEOC's own proposed timeline for providing guidance to justify its decision. The court noted that, the agency did not intend to issue a notice of proposed rulemaking until August 2018, and did not plan to issue a final rule until October 2019. It then went on to clarify that the EEOC indicated that the new rule would not be applicable until the beginning of 2021. As such, because the court issued its summary judgment decision in August 2017, the EEOC will have had a total of over 16 months to come up with interim or new permanent rules by the time the vacatur takes place. The court will also hold the EEOC to its intended deadline of August 2018 for the issuance of a notice of proposed rulemaking.

How should an employer respond?

Depending on where on the spectrum of corporate wellness one's plan falls, this decision warrants varying degrees of attention. For those plan sponsors offering a wellness component because it seemingly was the right thing to do considering its prominent placement on many conference agendas and email blasts, it may signal the end of such a program. For those plan sponsors who have aggressively expanded their basic wellness program to a robust population health and well-being initiative, these plans are likely already scrambling to learn more about this ruling and concerned that their program may be frustrated by the ruling and pending final rules.

Plans seemingly have several considerations such as to redesign their programs, eliminate incentives for the activities regulated by the EEOC or adjust their current programs to a design that falls somewhere in between no incentive and the EEOC's 30 percent definition. To make such a decision there are two key components to consider. These components are cost and engagement. While these may mean different things depending on where one falls on the corporate wellness spectrum, these components warrant a close review.

The cost to provide the program, the cost associated with the compliance risks of such a program, the cost of focusing time and resources on these programs in lieu of other benefits related efforts, and the cost that may or may not ultimately be avoided by such programs all must be reevaluated. To open the debate on the likelihood of achieving a tangible return on investment (ROI) on a wellness program would be folly. But, this ruling does provide the opportunity to stop and review each of these cost related questions relative to an employer's benefit plan.

The first question related to cost must be an examination of if such programs have taken away from other opportunities. Specifically, the ongoing evaluation of strategies that address the cost of each unit of health care received and the number of health care units consumed. Such strategies whose evaluation has remained idle may include but are not limited to vendor procurement initiatives, evaluation of vendor offerings such as clinical and disease management offerings and supply side initiatives such as narrow networks, plan design changes and engagement and advocacy services.

Another consideration related to cost is a review of the ROI of such a program and the impact that future regulations may have on such a program. Specifically, is an employer's program still viable in the absence of incentivized medical exams and collection of health information? Future guidance from the EEOC is coming; but certainly, the question becomes if such incentivized behavior and data collocation is now prohibited, how will that impact the design, associated costs and ROI of your program? Other related questions remain, like has the ROI already been achieved? Is the ROI and true value of these programs the engagement and attention of plan participants? In the absence of such incentivized programs or a wellness initiative, what many plan sponsors may find remains is an engagement mechanism. Certainly, such a mechanism may likely be the most valuable component of a wellness program; that is, methods that have been refined and tested to effectively engage with plan participants.

This concept of engagement and the effectiveness and meaningfulness thereof also likely determines how an employer proceeds considering this recent ruling. If the core of an employer's wellness program involves what this ruling impacts, incentivized medical examinations, disability-related inquiries, and/or genetic information collection by the employer, then plans must determine if it will risk continuing these activities or how the plan will keep participants engaged. Plans that include these components but have added additional components, such as education about health and other components relative to an employee's overall well-being, may determine that the medical examinations, disability-related inquiries, and/or genetic components have run their course but the more valuable component, engagement, remains.

One could argue that this engagement, even before the advent of this ruling, was the most valuable result of these programs. Historically, the trend has been to use this engagement as a springboard for activities and initiatives that create a health-conscious consumer relative to behavior and health care utilization decisions. While this approach will remain popular with many plans, this forced focus on wellness programs may temper such an approach. As such, there may be alternative or parallel uses for this engagement. For example, engagement may begin to be used for plans to more clearly communicate the:

1. value/plan sponsors cost of the benefits provided,
2. well-being initiatives and programming, including but not limited to financial well-being and work-life balance,
3. how the health benefits fit into the context of benefits and total rewards generally and nuances surrounding any employer enacted cost savings mechanisms with the plan.

So how should this engagement be spent? Certainly, efforts around consumerism and participant education around wellness will remain attractive options. But certainly, if the returns of such efforts have failed to materialize or stalled, perhaps this engagement can be channeled into some of the four alternative areas identified above. The value of benefits, the growth of well-being concepts and the concept and context of health benefits and other ancillary offerings are generally straightforward, at least conceptually, and many plans have begun gravitating down this path using technology such as robust participant portals or benefits administration platforms. The last mechanism may perhaps be the most contrary to current thinking. The success of the implementations of any change to the benefit plan or new initiative is certainly advanced by effective participant

engagement. Plan sponsors seeking to maximize this engagement may look to how this engagement can be aligned with new cost saving strategies.

For example, there are a variety of paternalistic supply-side strategies that can be elected by plan sponsors to ensure a participant is only able to select necessary and appropriate services, providers and drugs. Many approaches utilize traditional managed care concepts with a focus on data/quality analysis, controls on utilization, case management and coverage limitations. Some examples of supply-side controls include narrow networks and exclusionary drug formularies. Certainly, cost sharing must still be aligned within these strategies, but as with the 401k, plan sponsors must consider making the preliminary decisions to narrow the options and direct participants to a limited pool of options that will adequately meet their needs.

To build upon this engagement and its effectiveness, communications tools, advocacy services and dynamic enrollment platforms may be retooled to focus on how to use and maximize the plan. Plan sponsors may pause to consider a more moderate approach focused on the "managed" in managed care in light of the needs of their plans and participants. Under such an approach, priority should be given to managing the underlying bouquet of services that participants may access under the plan and engagement initiatives must be revamped to navigate the plan and not the health care system generally.

Conclusion

Plan sponsors should take this opportunity to reevaluate the value of their current wellness programs and initiatives. As many wellness programs have transitioned away from a ROI based on a reduction in medical spend and are moving toward ROI involving well-being and the avoidance of absenteeism and presentism, this may be an excellent time to reevaluate the best way to utilize the engagement that has hopefully been garnered under historic wellness programs. All such decisions should be made with a growing understanding that the trend toward paternalism in benefits is growing. Tools for helping employees select the appropriate benefit package to meet their circumstances, increased automation of retirement savings and student loan payments, required vacation or leave, artificial intelligence in disease management and care reminders all serve as examples of such a trend. The key question to be addressed will be if and how a health plan can reconcile consumerism with this trend.

Reference

AARP v. United States Equal Employment Opportunity Commission, No. 1:16-cv-02113 (D.D.C. 2017)