



**Workplace Wellness: Promises, Challenges,
And Legal Questions
Anthem, Inc.
Alliance for Health Reform
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ED HOWARD: And on behalf of Senator Blunt and Senator Cardin and our Board of Directors, I want to welcome you to today's program on the implications of a growing trend -- I guess that is redundant. A trend among employers who are offering so called "wellness programs" that are aimed at inducing healthier behaviors among their workers. They are hoping to engage their employees in their healthcare, get a healthier, maybe more productive workforce, reduce absenteeism and lower healthcare costs. And I understand that almost all larger employers now offer one or another of these wellness programs and in fact, so do most employers of any size.

Now, the Affordable Care Act included some provisions that were designed to give employers some more flexibility in designing and offering these wellness programs. Things like smoking cessation and weight loss and nutrition classes and the like. But some work advocates are raising questions about some of these programs. Not so much because of the behavioral changes that they are trying to bring about, but rather the incentives, both carrots and sticks, that are aimed at bringing about those behavioral changes. In fact, the equal employment opportunity commission recently proposed a rule that would restrict some practices that go beyond the guidelines laid out in the Affordable Care Act.

So in today's program, we are going to look at what wellness activities are in place, whether or not they are achieving the goals of a healthier workforce and lower healthcare costs and what their future is in light of the guidelines laid out and the legal challenges that are being mounted to some of these programs.

So we are pleased to have as a partner in today's program, Anthem, which among other parts of its business operates Blue Cross plans in -- I guess in about a dozen states and insures one in nine privately insured Americans. So we are very happy to have Anthem along.

I just want to do a little bit of housekeeping before we get to the program. If you plan on tweeting, which we would encourage, you can see on the screen the hashtag workplacewellness, which you can use. If you need WiFi to connect to do your tweeting or anything else, the instructions on how to do it are on the screen and on your table if you need it. Lots of important information in the packets that you were given as you came in, including more biographical information than I'm gonna be able to give you about our speakers. And a bunch of background materials that will also be available in digital form on our website, allhealth.org. You can also find there in the next day or two, a video recording of this briefing and a few days after that, a transcript, if you would like to peruse the actual words. Two things to anticipate, one is when we get to the question and answer period, you can use the green card in your packets to write a question or you can use one of the microphones that you see in the audience to ask your questions orally. And then there is a blue evaluation form that you are probably tired of hearing me ask you to fill out, if you are a regular at the Alliance briefings, but believe me, they are very important to us. We parse what you write and what you say, very carefully. So take a moment as we go along to try to fill that out and we will make these programs even better.

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So, let's get to the program. We have terrific panelists. As usual, they are going to give some brief presentations and we are saving the bulk of the time to respond to your questions and have a little dialogue among the panelists. And let me just introduce the entire panel now. Karen Pollitz at my far left, your far right, is a senior fellow at the Kaiser Family Foundation, where she tracks implementation of private market insurance reforms, focused on consumer protections. She has worked on the Hill with Jay Rockefeller, the founder of the Alliance. She has done a couple of periods of service at Health and Human Services and at the Georgetown Health Policy Institute. And she is going to give us a sense of how widespread wellness programs have become and the policy framework under which they operate.

Next to her is Dan Newton, currently the acting Vice President for Anthem's RHI subsidiary, where he directs the development of management of Clinical Programs and intervention using RHI's data analytics and technical applications. And Dan, we have asked to tell us about why employers offer wellness programs in the first place and how those programs get designed.

Next to me on my right is Sam Bagenstos, he teaches law at University of Michigan Law School where he specializes in constitutional and civil rights litigation. He's been on the law faculty; at Washington University, at UCLA, at Harvard. He was the Principle Deputy Assistant Attorney General for Civil Rights a while ago. He clerked for, among others, Supreme Court Justice Ruth Bader Ginsberg and he's offered to give us a preview of the King v. Burwell decision. He has a secret copy, I believe. Now, he and I both hold degrees from Harvard Law School, but guess which one of us graduated Summa Cum Laude and was Co-Director of the Law Review? I think you got it right. And we have asked Sam to look at some of the legal issues surrounding wellness programs, particularly from a consumer point of view.

And then finally, Katie Mahoney is the Executive Director of Health Policy at the U.S. Chamber of Commerce, where she is serving her second term of duty. She also successfully practiced health law and policy at Greenberg Traurig, a prominent D.C. firm deeply involved in securing agreements between managed care organizations and health systems on various issues and we are pleased to welcome her back after only a couple of weeks, after her appearance earlier this month at her hour briefing on the small group market, Katie is going to tell us about some of the successful wellness programs that employers are sponsoring and how some of the legal issues involved are viewed in the employer community. So that was not as brief an introduction as I had hoped, but we still have plenty of time for our panelists and we are going to start with Karen Pollitz. Karen?

KAREN POLLITZ: So I'm just going to jump right in and summarize for you today, information about workplace wellness programs from our annual employer health benefits survey. And also, from an issue brief on workplace wellness programs that my colleague Mathew Rae and I have prepared that is in your packets.

As Ed mentioned, most employers today in nearly all large firms, with at least 200 employees, offer some type of wellness program. But wellness is a broad term, encompassing a big range of different kinds of programs. Some are very limited. For example, just offering a wellness newsletter and others are more comprehensive, offering a variety of classes and coaching and other wellness services. Participation in wellness programs by employees generally has been low. The Rand Corporation, which conducted a series of reports for the federal government on workplace wellness programs, observed a median participation rate of 40%. So some employers offer financial incentives to increase participation. Our survey finds that 1 in 5 firms overall that offer wellness benefits, offer incentives to participate and more -- 36% among large firms. In some programs, the incentive takes the form of a gift card or cash or merchandise and in others, the incentive is tied to the health plan premium or the deductible or to contributions that the employer makes to a worker's health savings account.

When workplace wellness programs use incentives, several federal laws that prohibit discrimination can come into play. One is ERISA, which prohibits insurance discrimination by group health plans based on health status. So for example, a group health plan is not allowed to charge people more because they have high blood pressure. ERISA makes exceptions though for incentives that are offered as part of wellness programs. In 2010, the Affordable Care Act amended ERISA's wellness program standards and distinguished two different types of wellness programs. The first type is called a Health Contingent Wellness program and that is one that offers rewards based on health status. So for example, a program might increase premiums when they have high blood pressure, as an incentive to try to get their blood pressure under control. The ACA said that health contingent wellness programs are not discriminatory if they meet five standards, which I will get to in just a second. And then the second type of wellness program is called participatory. And participatory programs don't base rewards on health status or use incentives at all. And because they don't, the ACA regs say that ERISA non-discrimination rules are not implicated. So the five new standards for health contingent wellness programs don't apply, though other federal laws might apply.

So under the ACA regs that were issued in 2013, the five standards for health contingent wellness programs are, number one, a limit on the financial incentive. It can't be more than 30% of the total plan cost -- that the employee and the employer's share combined. That can go up to 50% of plan costs if there is a tobacco component to the wellness program. And it can be based on the cost of family coverage if family members are eligible to participate in the wellness program. Last year, the average cost of group health plan coverage was about \$6,000 for self only and nearly \$17,000 for family coverage. So, the reward or the incentive can be up to thousands of dollars. Health contingent programs also have to offer waivers or exceptions for people who can't meet the initial biometric target. They have to give people at least one chance per year to earn the reward. There have to be notice about the wellness program in plan documents and finally, these programs are required to be reasonably designed. Under the ACA regulations, reasonably designed means that programs have to have a reasonable chance of promoting health and they shouldn't be overly burdensome or a subterfuge for discrimination. Otherwise,

though, the reg is explicit in saying that the reasonably designed standard is intended to be an easy one to meet and scientific evidence that a program works is not required.

Now, most workplace wellness programs today are participatory. Only 4% of large firm wellness programs are health contingent and link the reward or penalty to meeting biometric -- link the premium, for example, to meeting biometric outcomes. For example, charging lower premiums for workers who have normal blood pressure. Also, in nearly six out of ten of these health contingent programs to date, the rewarder penalty is worth less than \$500. So, far less than what the ACA allows.

Now, something that firms offer more often through wellness programs is the opportunity to complete a health risk assessment. That is a questionnaire for workers to report information about their health status, their health history, risk factors and other information. Today, 36% of all workplace wellness programs offer HRA's and large firms, it's 51%. If the employer does offer a health contingent program, they might use the HRA or other biometric screening to determine whether the worker has earned the reward. But some workplace wellness programs, Rand estimates about 20%, just offer the HRA or similar screening. As the key component of the wellness program, with few or no other wellness services offered. Like wellness programs in general, employees have been not so enthusiastic about these medical inquiries, so employers have also started to use financial incentives for people to complete the HRA. Fifty-one percent of large firms that offer HRA's, offer financial incentives for employees to fill them out and in nearly two-thirds of the large firms that do this, the amount of the financial incentive, again, is worth less than \$500.

Just in terms of public attitude about workplace wellness programs, this is something we asked about a year ago in our Kaiser Health Tracking Poll. We found overwhelmingly that the public thinks it is appropriate for the employers to offer wellness programs that promote healthy behaviors. But by large margins, the public thinks it is not appropriate for employers to ask workers to pay higher premiums if they don't participate or if they don't meet certain health targets.

Now, the use of HRAs in financial incentives in wellness programs implicates another federal law, the Americans with Disabilities Act. The ADA prohibits employment discrimination. So, different than ERISA, and also prohibits employers from even asking workers health information that isn't related to their ability to do their jobs. But the ADA makes exceptions for voluntary wellness programs. GINA, the Genetic Information Non-Discrimination Act, has similar rules and wellness program exceptions. Until recently the EEOC, which enforces both laws has defined a voluntary wellness program to be one that does not require workers to participate or penalize them if they don't. Last year, the EEOC brought some enforcement actions against employers including one against an employer that applied large financial penalties to workers that would not complete the HRA. And employers objected to this enforcement action and said that it was inconsistent with the standards promulgated under the ACA. So this spring, the EEOC published a proposed regulation that would harmonize the ADA as standards for wellness programs with the ACA standards. The proposed EEOC rule recognizes two other kinds of

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wellness programs, those that are offered as part of a group health plan and those that are offered outside of the group health plan. For wellness programs that are offered as part of a group health plan, two new standards would apply under the ADA. One is a limit, again, on financial incentives, similar to the ACA. The financial incentive could be no more than 30% of the cost of self only coverage under the group health plan. And second, notice standards. Programs would be required to tell people up front what health information they were going to ask, how that information would be used and how it would be protected. And both of these new standards, again, would apply just to programs that are offered as part of a group health plan. The proposed rule also notes that different privacy protections might apply to wellness programs, depending on whether they are part of a group health plan. HIPAA privacy rules would apply to wellness programs that are offered as part of a group health plan, but wouldn't apply to programs that the firm offers directly, because employers aren't covered entities under HIPAA. And then the ADA has other privacy rules that would apply to both types of wellness programs.

Now, the proposed rule doesn't define what it means to be part of a group health plan. In our annual survey, the majority of very large firms with more than 1,000 employees say that most of their wellness benefits are offered outside of the group health plan. So if this rule is finalized, there could be a significant difference in the rules that apply to wellness programs, depending on whether or not they are part of a group health plan.

For all wellness programs, including the outside programs, the proposed rule also requires that programs be reasonably designed so not overly burdensome, not a centrifuge for discrimination and it also specifies that programs are not reasonably designed if they exist mainly to shift costs to targeted workers based on their health status. And finally, the proposed rules requests comments on best practices used by wellness programs today to ensure that they are designed to promote health and not to shift costs.

That brings me to my final slide. Back to the Rand studies which did evaluate the efficacy of wellness programs. On the question of whether wellness programs actually produce cost savings -- health cost savings, Rand said that they can. And they observed healthcare cost savings of \$30 per member, per month on average. But that was not across the board. Rand found that almost 90% of cost savings were associated with wellness programs that included disease management components, which improved the care for people who already have chronic conditions as opposed to lifestyle programs that prevent the development of health problems and chronic conditions. Rand also studies the effectiveness of incentives and on average observed that the use of incentives does increase participation in wellness programs by about 20 percentage points. But, Rand found that designing more comprehensive programs had nearly the same effect without the use of incentives. Finally, Rand describes some elements of successful wellness programs, including those that offer services that workers want and need, that are convenient and accessible and that collect data and evaluate what works. So, it appears that there are some best practices for wellness programs. I think Dan will probably talk more about those. And it remains to be seen whether these may be reflected in federal standards for wellness programs as these rules are finalized.

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ED HOWARD: Great, thank you, Karen. And Dan, you have a chance to pick up the conversation.

DAN NEWTON: So we will transition from maybe the -- I think what in terms of wellness programs is pretty well defined. Actually, it hasn't changed much in the last 30 or 40 years, people need to exercise more, they need to eat better, they need to sleep better, they need to handle their stress better. So those components and then aspects of health risk appraisals, biometric screenings, they have been around for a long time. So the issue isn't the "what" anymore, it's the how. And that's what I will spend a few moments talking about.

So this first slide in terms of anybody that may remember the days of Jeffrey Moore back in 1991, I believe, when he wrote the book *Crossing The Chasm*, it was really about -- the main message there was for the innovation and technology to really spread. You needed to adopt kind of a marketing model. You needed to really diffuse that innovation. You need to start to understand consumers and the marketplace in order to get widespread adoption. So I think that is where we are right now with both wellness and maybe kind of wellness particularly as it relates to healthcare, that there is lots going on, on that left-hand side of the continuum and as you saw in Karen's slides, engagement is low and participation and adoption is low and so the transition is -- I will over simplify, is maybe going from the model where we have been telling people what to do and somewhat torturing people what to do, maybe. To really starting to build relationships and having conversations. So it's about things like building -- you will hear, everybody is focused on the consumer experience. Or behavioral economics is very important in terms of what we say, how we say it, what kind of analytics we use to guide that. And then activation. And activation has an element of skill building, you know? I will get into that a little bit more.

This will be kind of reiterating what Karen had said, that adoption is slow. Even on our own studies, we did a lot of work with Gallup in the last couple of years doing all kind of studies on consumers, actually getting ready for the exchanges since we participated in exchanges and all the states that we are in. But that meant that we needed to understand -- start to build competencies around consumer segmentation and start to align what we understand about what consumers want and what products are being offered. And in the world of kind of wellness, like I said, its no longer about the "what", it is about the "how" and the "how" is, how do we get people to use these programs? How we do start crossing that chasm to get broader adoption, better engagement and the studies -- whether they are our own studies that we have done or any of the industry or a big kind of consulting firm studies, they all pretty much say the same thing. That the engagement levels are pretty low. Generally kind of under 30% for most of the programs. Although there is usually those same studies, there is a bit of, I would say, schizophrenia when you start serving consumers. There is lots of studies that show that they want these programs and then they identify the programs that they want and then they also say that these programs aren't available to them and then when they are available to them, they don't really use them. So there is a lot of work to be done in that element there.

And this is a study by Parks Associate that again, reinforces that point, not only is engagement low, but adoption is low. Meaning, so when you have the tools that are out there and you look at what people do, do they use websites, do they use the apps, are they using the tools that are available for them to manage their health, to find doctors, to engage with their physicians, to look for health information? You know, we know all the statistics in terms of internet access, cell phone access, so those things are no longer barriers. Everybody has access to them. But how people use them still has a lot to do to make it easier for them to use them to manage their kind of health and wellness as well as manage their healthcare benefits.

I have used this AON study, its actually a good study for anybody who is looking for this type of information. This is around kind of the consumer health-minded report, which was the name of the study. We have done our own internal studies as well and I would just say that all the studies kind of vector around these points, this is just easy to make it for the slide purposes. But, when you say, what do consumers want? They really want you to make it easy. The consumer expectation around the experience is driven by what they do in their everyday lives. How they shop for Amazon. How they shop at Zappos. How they hail a cab with Uber. I mean, the consumer experience is really high in terms of what the expectation is in the non-health world. So when they kind of gravitate to health and wellness, that experience isn't up to par. So, there is a lot of work to done to make things easy, make it personal. That means, make it meaningful, make it relative to me. Make it move me as an emotion. So that in order to become the drive engagement to drive better meaning and context, we have to think of ways of making things more emotional for the consumers so that they enjoy and they really get motivated by what they are using. And make it meaningful, obviously as an element of -- it has to have meaning at the consumer level. So it just can't have meaning to the employer in this case. To drive lower healthcare costs. It has to be meaningful and relevant to those who are utilizing these programs.

The key principles as part of that transformation process is this aspect of -- we really need to start building relationships with consumers. We need to be connected. We need in our communications -- and this is where behavioral economics can help, is to really develop and create relevance and context when we communicate and activation, again, is a concept about skill building and that is -- this concept of skill building in engagement is best probably represented in this study by the Center for Advancing Health when they really looked at interviewing all the experts around the industry and really looking at, what does it take for consumers to effectively manage their health in their current world that we are living in. And they kind of grouped I think about 42 different actual skills to these kind of ten or so kind of common themes. I mean, simple things about, do you know how to find a doctor? Do you know how to get there? Do you know how to pay for your bill? Do you know how to talk to your doctor? Do you know how to comply with your treatments? Do you know how to seek information to help you do those things? So wellness is going to be broadly defined more in terms of not things around -- I need to get people to stop smoking, I need to get people to lose weight. I think it's going to be more broadly defined in terms of how do I help consumers build the skills, give them the tools, to help manage their health. Whether its their health driven by the healthcare system,

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their insurance company or it's the health from just managing -- how do they stay out of the system? How do they keep themselves well?

From the insurance side particularly, there are many of those in government here, we generally don't do a good job of communicating and we also -- for the lawyers in the room, we also get focused on the wrong thing in terms of how -- anybody who has received an EOB and understands what that means, but understands that we spend a lot of time communicating things that really aren't important and the most important thing we need to say, we need to say simply and quickly. And that goes both what -- the employers are spending a lot of time, I know us at Anthem are spending a lot of time to try to get better at how we communicate to make things simple. I know even when we deal with providers, it's the same thing. We have to get providers to be a big part of the equation. To get them to communicate effectively with consumers. And when you get kind of employers, providers and the plans all working together and I think we will start kind of driving better success.

When you take the macro aspect of how do we get people engaged, how do we drive change, how do we get change to happen within -- particularly the concept of worksite wellness. I mean, those are defined populations and it's a great opportunity and there are different motivations. Ed mentioned those motivations around not only cost, but satisfaction. Engagement in employer is taking on a new meaning too, it has to do with satisfaction. Does my workforce want to come to work? Do they like working here? So wellness takes on a relationship to -- and a mechanism by which you can make your employees happy and make them satisfied, drive your engagement scores, so do the annual satisfaction surveys. In this particular model, the short message here is that you really need kind of a collaboration of tactics. You need to work on culture and environment. You really need to understand kind of group influences and you need to understand individual influences. So if you want to really drive population change and get adoption to go high outside of that 15 - 20% to 60, 70, 80%, you really need to think about -- if it's a worksite, how do you bring groups together? That a theme of wellness that often takes the form of challenges or using social media or bringing people together, combined with individual tactics, which might tie into things like incentives or behavioral economics, which is how we message and how we incent, to policy issues and leadership issues and communication issues. But bringing those kind of critical elements together, it's the only way you will kind of both cross that chasm from a broad adoption standpoint and move individual change to large scale population change.

And then finally, the message here is, it's really about -- there is no magic bullet, I think, when it comes to both wellness, adoption, engagement, it's really about doing a lot of things consistently. You know, Karen listed all the different programs and the message there was, you need basically -- I will use the fishing analogy, where you need kind of different bait for different fish. So if you think about from a wellness perspective, you need a lot -- you need a variety of programs to attract people and you need a consistent effort around communication, making things easy, focusing on what has meaning and motivation, leveraging groups and really focusing on the culture. And it seems easy -- it is easy to say, but hard to do and that is why we haven't been very successful. And so it's

kind of success by a thousand nudges. It's a continual, small process of bringing those forces together to drive better success with wellness programs.

ED HOWARD: Let's turn to Sam Bagenstos.

SAM BAGENSTOS: Thanks very much. So, I really appreciate the opportunity to talk at this briefing. As you seen, my dean requires me, wherever I speak, to display the block M, which is the insignia of the University of Michigan and to give a pitch to say, the University of Michigan Law School is an outstanding law school and you should hire our graduates, you should go to the University of Michigan Law School, it's great. Okay, now I will get paid this year, thank you very much for indulging me. Yeah, you think I'm kidding, I have a tough dean.

So in any event. So what I'm going to talk about, moving more from the sort of policy questions and the program design questions to legal questions, talking about the application particularly of the Americans with Disabilities Act, to workplace wellness programs. And in particular, leading up to a discussion of the EEOC's proposed regulations on workplace wellness programs, which you have already heard something about and which the comments have closed on this past Friday.

So, a couple of things about the ADA. So, first of all, Title I of the ADA applies to employers. It applies to everything employers do. There are other provisions at the ADA that might or might apply to insurers, Title I might apply to insurers as well, but I'm going to focus on employers in particular here, because they are really the focus of Title I of the ADA and of these new EEOC regulations. And there are a couple of relevant aspects of the ADA to workplace wellness programs. So the ADA is an antidiscrimination statute, prohibits discrimination against people with disabilities, adopted 25 years ago, overwhelmingly in a bipartisan vote in Congress, signed by the first President Bush, the second President Bush signed a law expanding that statute and overturning some restrictive Supreme Court decisions. It's a statute that has gotten very wide bipartisan support through the years. And what it aims to do is it aims to prevent discrimination against people with disabilities in all walks of life, particularly in Title I in employment. Two crucial aspects of the ADA in employment for this. First is the ADA defines discrimination to include the failure to make reasonable accommodations to people with disabilities. Why is that? Well, it seems pretty obvious. If you tell somebody, hey, we are perfectly happy to hire you, even though you use a wheelchair, but by the way, your office is in a place that you can only get to with stairs, obviously we don't think of that as an equal opportunity. So that concept of reasonable accommodation, failure to provide reasonable accommodation as discrimination is central to the ADA as it applies to wellness programs, the basic question is, if you have a wellness program, whether its an outcome or health contingent wellness program, on the one hand, or a participatory wellness program on the other, does it make a accommodations? Does it make exceptions and waivers for people with disabilities whose disabilities make them unable to satisfy the outcome that is incentivized by the program? Or to participate in the participatory aspect of the program. If you say, look, we are going to give you these benefits if you attend this gym. But the gym is not accessible to people with disabilities,

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that needs to be reasonably accommodated. If you say, you need to lose this amount of weight in order to get this incentive, but you can't lose this amount of weight because of some medical condition, that constitutes a disability, that needs to be reasonably accommodated absent undue hardship. There is really not that much question at this point about that, at least visa vie the EEOC.

The more central aspect to the recent EEOC regulation is the provision governing medical inquires. The ADA contains extensive provisions regulating how employers can ask questions of their perspective or current employees about medical conditions. And there is a reason for that, which I will talk about, but the central prohibition for existing employees is that an employer can't ask questions of an employee about medical status unless doing so is job related and consistent with business necessity. Now, I'm going to let you in on a little secret: nobody knows what job related and consistent with business necessity means, but it suggests at least some significant degree of justification. It can't just be, well, we thought it might be a good idea. There has to be some actual basis for believing that this significantly advances some business purpose of the employer. This has been regarded by many employers as a substantial obstacle to engaging in workplace medical inquires and so there is an exception that was written into the ADA in 1990 because wellness programs existed then too, which says that if an employer provides voluntary medical examinations or voluntary medical histories as part of an employee health program available to employees at the work site, then that is exempt from the ADA's restriction on medical inquirers of an existing employee. So the basic question that this raises for wellness programs is, are wellness programs voluntary? HIPAA, the ACA, they have numerical thresholds in the statute for what constitutes an acceptable program, at least under outcome contingent programs, as you have heard from Karen. Where there is a 30% or 50% maximum in terms of financial incentives. There is no numerical threshold in the ADA as a statute. It's just this word "voluntary". Well, another secret that lawyers will tell you, nobody knows what the word "voluntary" means either. So this creates some degree of uncertainty. Why do we have this provision? Well, because when employers find out about medical conditions, particularly about hidden disabilities, often in the past that has been the trigger for discrimination. That was something that the framers of the ADA in 1990 were extremely concerned about and that is why they significantly regulated the degree to which employers could force employees to give u information about their medical status. Because they saw it as a trigger for discrimination and there were many prominent cases at the time in which employers found out about HIV status or found out about diabetes or epilepsy or other conditions and when they found out, engaged in discrimination.

So what has led to the latest degree of upset about the EEOC and wellness and what has led to these recent regulations? Well, so the EEOC, last year, brought three significant cases challenging employer wellness programs as not being voluntary. It's not satisfying the voluntariness standard. So Orion Energy, the allegations were that the employer said to the employee, "If you don't participate in the wellness program, we are going to shift the entire medical health premium to you, cost to you." And allegedly, eventually fired her. In the Flambo case, the next case that the EEOC brought, the allegations were that the employer cancelled the employee's health insurance and again, shifted the entire

premium cost to the employee, which the employee refused to undergo a health assessment. And then finally the case for people, like the person who is sitting to my right and probably appropriately to my right, was the last straw. I'm trying to keep you guys awake here, its lunch time. So, what was the last straw, I think, for many people in the business community, was this Honeywell case, where at least as alleged by the EEOC, and there is great dispute about these numbers, the employer said, "If you do not participate in the biometric screening as part of a wellness program, various things are going to happen to you. Various costs are going to apply, you are going to lose various financial incentives we would otherwise give you, all adding up to about \$4,000 at the extreme case." EEOC filed for a preliminary injunction in that case and lost. This led to a great deal of upset in the business community about the EEOC going after wellness programs and particularly going after wellness programs that would seem to satisfy the ACA and HIPAA standards for voluntariness. Obviously Orion and Flambo don't really look like they would satisfy the ACA and HIPAA standards, but Honeywell looks more on the cusp. So much reported in the news, much reported in the news, the business round table, went to the White House and said, "Hey, White House, we are gonna withdraw our support for the ACA." I have never understood what that means exactly. "We are going to withdraw our support for the ACA, if you don't do something about this EEOC." Then what happens? Well as post hoc propter hoc, the EEOC comes out with a proposed rule that says, "Okay, fine, we are gonna try to harmonize the voluntary definition under Title I of the ADA with the ACA and HIPAA rules." So what they said, among other things and Karen elucidated a lot of it, what they said is, "It's a voluntary wellness program if an employer provides a financial incentive of up to 30% of the cost of the employee only coverage." So an employee who refuses to participate in a participatory wellness program or in an outcome contingent wellness program, can be penalized up to 30% of the cost of employee only coverage. That averages out, as you heard, to about \$1800 a year. That averages out. So for some people it's going to be more than that.

So a couple of questions about this. One question about this is, is this a fair interpretation of the word "voluntary"? I told you, lawyers don't know what the word "voluntary" means. But I think a fair question to ask is, if you are a person who is working for a living, living paycheck to paycheck and you are told that you are going to have pay an extra \$1800 a year out of your pocket if you don't submit a health risk assessment, is that a real choice? Is that a meaningful choice that you get to make? Is that something that we would call voluntary? Under prior EEOC interpretations, as Karen pointed out, that would not be understood as voluntary -- going back to 2000. But under the new EEOC proposed regulations, it would be. One question. The other question is, well, why do we need this 30% threshold? The EEOC said we needed to harmonize with the Affordable Care Act. A couple of things I would say about this. We have obviously moved to the more argumentative truculent side of this discussion and it's going to get even better. But in any event, we need this to harmonize with the Affordable Care Act. Do we need to harmonize this with the Affordable Care Act? Of course, employee benefits are regulated often by different statutes with different obligations. ERISA has different obligations from the age discrimination employment act from the ADA. That is something we accept all the time. There is no particular reason why wellness programs should be any different.

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And in any event, the EEOC has not proposed to harmonize the ADA standards with the Affordable Care Act standards. The Affordable Care Act standards are 30% only for outcome contingent programs and they go up to 50% if there is smoking cessation involved, not true here. And it's 30% of individual or family health coverage, whereas the EEOC has said 30% of individual coverage. I suspect that the Chamber of Commerce believes that sort of arbitrary, but in a different direction than I do. So, this is not in fact harmonization and this is not in fact required by the Affordable Care Act in any event. Instead, what we have is the EEOC fundamentally changing its view as to what constitutes voluntary in a way that is not consistent with a common sense understanding of what most workers would experience as voluntary.

So that is what I have to say and I think I'm officially done. Send me nasty emails if you don't like my presentation.

ED HOWARD: We will be monitoring Katie's thumbs as she is speaking. Katie Mahoney, please.

KATIE MAHONEY: Thank you, it's a pleasure to talk with you all today. Yeah, we are gonna end with a blast, I guess, today. I would like to level set a little bit. I think this is going to be a fascinating discussion and who knew people could get so worked up about workplace wellness programs? I think everybody thought that -- at least my constituents view them as sort of, Mom and apple pie, but they certainly are bringing out the vitriol and I think a lot of different ways.

I guess I would like to thank my co-panelists for kind of setting the legal landscape for explaining efforts to engage consumers for giving an overview of the proposed rules and how they different from the final rules that were issued by the ACA and I would like to focus on sort of what is an employer to do in this landscape. Before I get into that though, I would like to step back a little bit and say, I think that regardless of people's view of the ACA during the legislative debate or now, everyone sort of shares a common view about what should health reform either in the past or going forward, look like. And I think those goals are among us all, to improve access to coverage, access to services, improve health and lower unnecessary costs. And I think when you get into, how do you do that, that is where kind of the rubber meets the road, but I keep those overarching goals as a framework as we think about workplace wellness.

I also call into folk's consciousness, the idea that the ACA introduced about the concept of a "free rider" and the concept of individual responsibility and shared responsibility as to what do we as a country need to do to kind of help ensure that folks are covered either individually or otherwise. And with that, I will get started.

So, I would like to talk a little bit about sort of what are the legal parameters and we have heard some detail and background, but strictly from the view of the employer. What has been the legal landscape for employers? What is permissible under the ACA, which has been sort of the most recent statute enacted to deal with workplace wellness programs.

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And I think most folks view laws that introduced more recently as building on those that have been introduced in the past and certainly the provision and the ACA that dealt with workplace wellness was a bipartisan provision, which I think was rare with the ACA, but this was a bipartisan provision that folks believed would help improve health and help improve individual awareness of their health and help encourage people to take an active role in improving their health. There has been a long road for the tri-agencies to determine what is permissible under the ACA and we will talk a little bit about that. And I think as my colleague Sam mentioned, there has been this surprise in the proposed rule that the EEOC issues as sort of an end of the game kind of throwing down of the flag when folks sort of had a sense that the legal parameters had already been set.

As Sam kind of detailed rather quickly, and I'm sure you all are familiar with, the ACA included a provision in the law that said premiums may be varied by employers that have workplace wellness programs by 30% and up to as much as 50% as provided by the secretary. We went through a very long process, working with the administration as I think the other constituents did, in trying to define what that meant. And certainly there was language in the ACA provision about the fact that this could not be used in a discriminatory manner and that it needed to comply with prior statutory provisions. As far as the regulatory implementation goes, I think that this is important when you think of it from an employer. And when you think of it from, if I'm trying to follow the rules, and I am working through the process of understanding what that means, what does this current landscape do for the employer community? So as we know, the ACA was passed in 2010. We waited for tri-agency rules to understand what the ACA provision about varying premiums meant in terms of this ACA workplace wellness provision. The tri-agencies issued a proposed rule in 2010; we fought very hard to improve the rule. I think we were at the business community, the Chamber, speaking for the Chamber; had a little bit of a different view about these workplace wellness programs. And we are a little bit frustrated that they were viewed in such a negative way. The term that Karen repeated and I think Sam used as well, as a subterfuge for discrimination. Employers have been offering workplace wellness programs for a very long time. I know that the Chambers worked with Harkin and others over the past decade to establish an annual workplace wellness week. We have put out publications highlighting the various programs that employers have that have really helped employees to identify their health risks and get them, if they choose, take steps to improve those conditions and head off chronic conditions as they may be identified. The final tri-agency rule came out in June of 2013, so again, it was a seven, eight month process and those rules finalized in June, were applicable for plans beginning six months later. I think that is somewhat interesting that the final rule was finalized in June and the determination was made that those were the rules that we are going to apply to plan years beginning on or after January 1st, 2014.

So, it seems like the agencies told employers what their responsibility is to do, to comply under the ACA. As Sam mentioned, I think we would agree with the challenges that were brought against Orion and Flambo, I think that those provisions, those workplace wellness programs clearly violated the ACA and were what we would suggest are bad actors in a space of generally good actors. We had issue with the Honeywell TRO and we are pleased to see that the restraining order was denied. There is no further litigation

being alleged or brought against Honeywell. But that remains very confusing for employers, because although the temporary restraining order was denied, we now have these proposed rules that offer very different parameters for employers and their workplace wellness programs. Not only do the proposed rules that came out on April 20th that we filed comments on, on Friday, which I would be happy to share with Ed if he is able to post them on the website. I was remiss on not sending them along sooner. We walked through our frustration with the proposed rule and I think first and foremost one of the frustrations is the EEOC, even though the employer community is now working to comply with the ACA final rules that came out last June. Now we are in 2015, a year after those final rules were supposed to be applicable and we have got another set of proposed rules that completely don't harmonize with the ACA final rules. And not only do they not harmonize with the ACA rules, they don't harmonize on only one issue. So the proposed rules specifically said, these proposed rules govern ADA and then in a footnote, it suggests and states I think pretty clearly that there will be further proposed rules -- there will be a further rule making process that happens with regard to GINA and potentially Title 7 and the ADEA. So not only are you thrown up in the air, employers, in terms of knowing what you need to do to comply with the ADA, because guess what, those rules don't look like the ACA. But we got a whole host of other rules that are coming, so get ready.

I guess I would kind of conclude with saying that our frustration is with a provision that we view as a very bipartisanly passed provision, an effort that is sort of Mom and apple pie when you look at the majority of employers and what they are doing to try to help employees identify health risks and improve their health outcomes and identify chronic conditions before they become severe. And this -- not only the process that the EEOC is going through in terms of a piece meal process where it's issuing just a proposed rule on ADA and saying, "Hang tight, we've got more coming." But also the fact that its now issued these proposed rules well over a year and a half after the tri-agency rules were finalized, really leaves employers scratching their heads and is going to have, I think a tremendous if not already has had a tremendous chilling affect on the ability for employers to offer workplace wellness programs that they feel appropriate comply with the law and do best by their employees and protect them from unnecessary litigation.

So with that, I will stop and I'm sure we will have a heated discussion.

ED HOWARD: Thank you, Katie. Let me just clarify something, speaking as an alum of the House Aging Committee staff years ago. ADEA is the Age Discrimination and Employment Act.

KATIE MAHONEY: Yes.

ED HOWARD: Alright, we've had a lot of relatively complicated information thrown at you and now you get a chance to both clarify and take issue with and call into question or reaffirm any of what you have heard. You can do that, as I mentioned, by either filling out a green question card and holding it up or going to one of the microphones that are set up in the audience and you can ask your question in person -- if you do that, we would

ask if you would keep your question brief so we can get as many in as possible. Identify yourself and any affiliation if you have it. And I believe you were first.

CAROLINE POPLIN: I'm Dr. Caroline Poplin, I'm a primary care physician, I would like to ask about changing behavior and getting someone to take a pill for hypertension or another pill for cholesterol, that's pretty easy. But getting people to change their diet, do exercise and lose weight, is very difficult. There are people in this room who would have a lot of trouble with a plan than required weight loss. Specifically, how many employers - - this is for the Chamber person and the Anthem -- leave time during the work day to exercise? How many provide facilities? When I was at EPA, they had what was called a stress lab, which was open to executives only. Under the Democrats, it was open to everyone. When I worked for Bethesda Naval Hospital, there is a federal regulation that says you are entitled to 45 minutes a day to exercise. The military of course got that because it's required. When I asked my employer, the active duty guy I was working for, if I could have 45 minutes a day to exercise, he laughed at me. This was a law. So, how many employers provide opportunities during the work day and facilities to do exercise?

KATIE MAHONEY: I have a couple points I will try to make and then try to answer your question. First, there are reasonable accommodation provisions that are pretty significant. So there is no requirement, necessarily, to lose weight. It depends on whether you are talking about a participatory program where you kind of go to the Weight Watcher meeting and you have been identified as someone with a BMI and these are of a certain level or whatever the parameters are. And here is a slew of different opportunities that you can try to improve your health with that. Whether its Weight Watchers, whether its gym membership, what have you. So I think to just kind of put a fine point on the requirement to lose weight, I think there are reasonable accommodations about that for diabetics, for other people. There are provisions within the ACA final rule and as well as, I think, mentioned in the proposed rule about getting a note from a physician or a doctor to let your employer knows or your insurer know that you need a reasonable accommodation. Secondly, you know, I think that this question about whether employers provide time for an employee to exercise. I think that is a really complicated question and I'm sure you are not surprised to hear me say that. But I think again, in terms of shared responsibility, there have been questions about a lot of things. Whether an employer allows an employee certain time to do certain things. I think when we look at our lives, if it means waking up a little bit earlier, going to be bed a little bit later, if it means using your lunch hour to go take a half hour walk and then eating lunch at your desk. I mean, I think there are certain -- and it's tough. I mean, employers are offering healthcare coverage and to some degree have a paternalistic role on the one hand and then on the other hand, I think that there is a role for the individual to work within their day and make correct choices.

CAROLINE POPLIN: Well, it's the difference between helping someone do something and telling someone to do something.

KATIE MAHONEY: Agreed and I think what we are seeing and what I have seen in most of our employer businesses is that these workplace wellness programs are designed

to help. As Karen noted, participation has been very low. So if you are trying to improve the overall health as a primary care physician, I'm sure you appreciate wanting to improve the overall health of a population and encourage people to do that. This is a way to encourage people to do that.

ED HOWARD: Dan?

DAN NEWTON: Yeah, I guess -- I don't have a specific answer to your question of how many, but our surveys do show that time and -- that the issue of employers allowing time for their employees to work is a barrier. So, it's one of the top barriers to participation. But I think the time is changing in terms of the facility base models to now focus on simple things like activity and the Fit Bits of the world and all the monitoring devices, the Apple watch are moving into -- and even the behavior theory is kind of very focused on taking small steps and not really making big change. So there is going to be probably a bigger push to just get people to get moving, to get small types of change and kind of monitoring going. But it's clearly a barrier in terms of driving participation, is that issue of access and it's really a policy level. And if you take that one slide that talked about kind of the individual, the group and the environment -- because you can actually have the policies, but if you don't have leadership, you don't have communication, you don't have even smaller -- if you have a bad supervisor, you are not going to have -- you need to support across the organization of all levels, even if the facility is there and the policy is, you can do it. If there is a disconnect between policy and reality, meaning that is where its often a problem as well.

KAREN POLLITZ: This isn't something that we survey, but the Employee Benefits Research Institute did survey reasons why people don't participate. That is cited in our issue brief. One of the main reasons was that the program -- there wasn't enough time to participate or that it wasn't conveniently located.

ED HOWARD: There is a question on one of the cards that just got passed forward, asking whether these low participation rates are stable or are they growing because of the increased emphasis on communication and people being able to choose from good programs? Is this something that is actually a trend, if you will?

DAN NEWTON: You mean in terms of a technique?

ED HOWARD: No, in terms of the percentages that you showed on your slides that were relatively modest. Are those different from similar figures that might have been generated a couple of years ago?

DAN NEWTON: No. They have been fairly stable. I was just presenting in Miami last week and I threw up a slide and it showed kind of an adoption curve and -- but it was a slide I put up 14 years ago and the adoption hasn't really changed too much. But then I think that is part of that crossing the chasm aspect in terms of, until we kind of take this marketing model, drive consumers and really start to understand what it takes and start

leveraging kind of that multifaceted approach. That is when you are going to start driving those numbers higher.

ED HOWARD: Yes, ma'am?

LISA SCHLAGER: Thank you, my name is Lisa Schlager and I'm with an organization called FORCE, which stands for Facing Our Risk of Cancer Empowered. We represent the hereditary cancer community, a community which has an excess of 80% chance of developing cancer in their lifetime. Frequently breast or ovarian cancer. I'm sure you are all aware of the Angelina Jolie story. So, we are very concerned about this, because it's a slippery slope. We saw that the GINA Law, the Genetic Information Non-Discrimination Act is going to follow this and you talk about reducing cost and access to services, which is fabulous. It encourages people to exercise, great. But if you want to improve healthcare and especially mental health, there is a big difference between providing rewards and assessing penalties. And if you are going to penalize somebody potentially thousands of dollars because they choose not to participate for fear of revealing information that may be something they don't want to share with their employer or the people around them, you are creating the complete opposite of your goal and that is going to put stress on individuals and their families, in many cases, individuals who are already aware of their healthcare issues. In our case, we have people who need to have MRIs, mammograms, all kinds of screening on a regular basis, which frequently is not covered by insurance. They are already paying huge out of pocket costs. Now you are talking about potentially penalizing them for not wanting to reveal that they have a BRAC mutation or that they have anxiety or depression, when they are already aware that they have these things, but they are fearful that it's going to be used against them in some way. So I don't see how this is gonna help workplace morale and overall health and wellness unless the insurers start making sure that all these people who have all these conditions can actually get the services they need with little or no co-pay and can promise them that there is not going to be a penalty, which is exactly what this is. If you are telling someone that you are going to reward individuals who participate, but then it's actually a penalty by assessing \$2,000 - \$3,000 for the individual who is fearful of participation, that is not improving wellness. That is actually going to be hurting individual and mental health overall. So, I'm interested to hear your perspectives on this.

KATIE MAHONEY: Sure, thank you for the question and I think there is a lot of misinformation out there as far as who gets access to the information that is reported on these health risk assessments and through these workplace wellness programs. The employer does not get this information directly and I hope that Dan maybe can speak a little bit more artfully than I can, or perhaps Sam or Karen, there are some very concrete walls and firewalls of protection that prevent that information from being distilled up to the employer on an identifiable basis. So completing -- well, I understand the fear is very, very real. I hope that through panels like this and others, we can educate the community to understand that that information is not given to employers. It's often not given to the insurers; it's typically given to a third party program director that manages these workplace wellness programs, number one. And I think, number two, one of the whole struggles between voluntary versus penalty, versus incentives, is trying to find that sweet

spot as to well, what constitutes an incentive? What constitutes a penalty and what amount is coercive and what amount is voluntary? And I think our -- that is a tough question. I think our position would be that the provision in the ACA, which was passed on a bipartisan basis, set a standard for determining what was appropriate. The 30% versus the 50%. And if we want to change that, that should happen through statutory change. But I think that that's kind of what -- we are just trying to comply with the law in terms of what Congress determined was the appropriate threshold. Then I guess the only other piece is, in terms of a hereditary cancer scenario where an individual has a disease, a workplace wellness program wouldn't penalize someone for having cancer. They identify programs that can be used to help improve outcomes and I see you are probably going to give me some feedback --

LISA SCHLAGER: Not everybody who has this, has cancer. In fact a large percentage of individuals are called "unaffected carriers" meaning that they are just at exceptionally high risk. Someone like myself.

KATIE MAHONEY: Okay, so either way, if you are a carrier, if you have it, there is no workplace wellness program that I am aware of, that would say, oh, you have the gene; you are going to pay more. That's against the ACA statute. That is not going to happen, as far as I'm aware. Then the last point and I will let my co-panelists address any issues if they would like to, is one of the many, many things that is so difficult about healthcare and health reform, is there are so many terrible diseases and conditions that are very expensive to treat and very expensive to heal and one of the things that I think our country continues to struggle with is, if you have a private sector healthcare system like we do, where people buy insurance to cover conditions and services, there is a real tradeoff between no out of pocket, 100% coverage of all services and premiums. And an actuary and a statistician could explain to you from the insurance segment much more artfully than I could, that there is a real tradeoff to that and while I certainly would hate to be the one to determine what conditions are covered and what conditions aren't covered and at what levels, it is a mathematical conundrum and that sounds very harsh, but in terms of the system that we are living in now with people buying premiums to cover certain services, that is unfortunately the system that we are working within.

ED HOWARD: Karen, you were talking in your presentation about the lack of difference between a penalty and a positive incentive. You might address that since that is one of the aspects of this.

KAREN POLLITZ: Sure, so I mean, the regulation actually defines reward as avoiding the penalty so at some point its kind of two-sides to the same coin. I think people may perceive it differently. Under one program that I am aware of, that someone I know belongs to, their employer this year decreased the amount that they will pay toward the employee's health plan premium. But if employees participate in the wellness program, they get a reward of getting the employer contribution restored to what it was last year. So, is that a reward or is that a penalty? I think it can become a little bit subjective in understanding. If I could just mention though, on the privacy question that Lisa raised and that Katie just spoke to, I think concerns about privacy of information is another

leading reason that people cite in the Ebrey study for why they don't want to participate in workplace wellness programs. And as I mentioned, different privacy rules do apply, depending on how the program is structured. I think across the board there is a rule, as Katie mentioned that if any information is shared with the employer, that it has to be de-identified. But there is a concern, I think, in small firms, that process of elimination can sort of re-identify somebody and that even in larger firms, there are other increasingly sophisticated technologies to re-identify de-identified information and as far as I know, none of the federal privacy rules prohibit re-identifying de-identified information. So I think that is one concern, but secondly, I think there is a general concern that health information collected through wellness programs can essentially be commercialized. Dan even mentioned products and social media and other services that may be offered as part of these wellness programs and there is some evidence that vendors who market wellness programs to employers have business partners that are interested in marketing to individuals, whether it's Fit Bits or classes or other kinds of wellness services. Drugs, devices, and the wellness programs conveniently collect personal information that could facilitate that marketing. One HRA that I looked at include questions, not just about your health status, but what magazines do you like and how do you prefer to get your news. Then on the website, where people take that risk assessment, the authorization to share your personal information with the business partners is just sort of passively given, just by using the website. And if you click around on the obscure little links, you will find that it says, "By using this website, you agree to let us share your information with our partners." So I think there is a concern that personal health information that is collected through these wellness programs could be shared pretty widely. Not just the employer, but widely. Then once it's out there, it's out there and it's not private anymore and lots of different people could get access to it and I think people do have concerns about that.

ED HOWARD: We have a number of other questions that raise privacy matters, but I do want to make sure that folks at the microphones get a chance.

RON MANDERSCHIED: My name is Ron Manderscheid, I'm the Executive Director of the County Behavioral Health Director's Association. I want to raise the public health question -- most of what you all have talked about is very individually focused and the U.S. is a very individually focused society, however a person's health is only partly due to what that person does. It is also hugely due to what we call the social determinants of health -- poverty, discrimination, poor health education, etc. It's hugely due to the foods we eat -- we eat high fructose foods in the United States, which cause obesity. So there is a whole secondary dimension here if we are going to move to a culture of health and well being, which we need to get on the table. And the Affordable Care Act, I think, begins to do that, but does not go far enough, so I would be very interested in the panel's reaction to this and how you would build that out of where you are coming from here. How would Anthem build out to this? Build out to communities. How would the Chamber of Commerce begin building out in this direction?

DAN NEWTON: That is a huge problem and I think we are making progress. So with Anthem -- maybe beyond Anthem, right? So the movement towards ACO's -- accountable care organizations that really focus on coordination of care, that integrate

care, which includes pay per health, is one step to help improve that. I know at Anthem we have a huge kind of community focus. We have been working with kind of Gallup and Anthem on everything from kind of well being index, we were actually -- we had a health index state by state where we actually scored in terms of our performance goals, even as associates and trying to move that needle. But I think it's going to be -- then you think what happens in Medicaid. A lot of the Medicaid and Medicare markets are totally driven by our relationships in the community with social workers, knowing the local resources, actually having boots on the ground, working with everything from the church groups to the community organizations, to the provider network. So it's the only way we can actually move the needle and some of the metrics around those kind of Medicaid metrics. So it's certainly a start. There is a long way to go there, but I know from Anthem's perspective in the last couple of years, we have made a lot of kind of improvement in migration in terms of how our medical teams, how our programs come together and how they start to bring behavioral health issues into the broader kind of program offering and integration into those models.

SAM BAGENSTOS: I think there is something really profound, actually, about that question. Because what wellness programs are, is they are fundamentally individual. They are fundamentally about; let's change the individual behavior of this particular worker. And it says, look, the vector of regulation is going to be from the employer to the individual as opposed to if there are -- to the extent there are aspects of health that relate to a broader community, are we going to change that? So I think to some extent, to take as a given that the way that we have to improve health outcomes is for employers to be telling their employees what to do in their individual behavior and their private lives, is very blinkered. And so I think its really important that you brought that perspective out. I also think there is a community effect in a different way on groups of people with various conditions. We heard about cancer, we heard about -- I talked about people with other conditions that are disabilities under the ADA. When these programs become barriers to employment for large numbers of people with certain kinds of conditions, that also has ongoing health effects. So I think that once we start to think about this from the perspective of the social determinants of health, then the justifications for the kind of aggressive wellness programs we have seen get a lot weaker.

KATIE MAHONEY: Just one point I would make -- I know we want to cover more questions. I don't view it as the employer dictating what the employee has to do to improve their health. I view the employers role as trying to connect the nexus between the individual and the community and we are at the U.S. Chamber, working very closely with different communities across the country through our Foundation. We have partnered with the Robert Wood Johnson Foundation to look at what can employers do within their own communities to help improve health? Realizing that some of the largest employers in various communities are hospitals, so what sorts of health fairs can happen? What sorts of access to healthy foods can employers provide to their employees in the cafeteria? So I think that there is a more -- and I feel sort of silly even saying it after that comment, but a more benevolent approach, I think from the employer angle of looking at how can we as a community within our business try to improve the population that we work with. So, my thoughts.

KARIN FELDMAN: Karin Feldman from the AFL-CIO. Katie, Karen, we have had many discussions on many topics. What I'm befuddled by, with employers and their love of wellness programs is that absolute lack of evidence that they work. Yet, employers fought hard for the 50%, which was discretionary, they are fighting back against the EEOC, ADA rules. And I am quite concerned that it is sort of blame the worker approach to healthcare. What would make you change your attitude and take the broader view that was just articulated? I don't see employers doing it, I'm glad you do, Katie and Karen, if you could tell us some about whether these actually save money. That would be helpful, thank you.

KATIE MAHONEY: You know, I think what we have seen is that when you look at employers that have a workforce that has significant retention -- so it's not going to save money over the short term. I think it's an investment and so depending on the employer and depending on the workforce and depending on the program, you know, and I am remiss that I don't have the statistics, there has been some return on investment.

DAN NEWTON: Yeah, I mean, to me there is pretty good evidence that such programs work. I mean, there has been studies all the way back to the -- kind of the '70s, early '80s and there have been multiple -- I actually did studies in the early '80s with the government around [unintelligible] comprehensive medical screening with wellness programs and from the employer perspective, you are saying, do they drive costs? I would say if you just take pure medical costs and I think that's Katie's point, sure there is not going to be immediate actuarial linear savings. There is probably going to be more like a three year to five year savings. But employers do this for different reasons and there is clear association, things around productivity, around absenteeism, around the association between health and risk and disease and cost. So to me, the employers are driving this, I think, from the perspective of, you know, very simple concept, a healthier worker is a more productive worker. And that is the motivation. I think there are plenty of studies over the years that wellness programs will drive lower cost, but it generally takes about three to five years and the ROIs and them are generally in a range of about 1.4 to 1.6. So in terms of, if you look at all the studies that have been done on those.

KARIN FELDMAN: Studies that aren't peer reviewed, studies that don't mathematically work -- I think Rand is suggesting there are serious problems with that kind of analysis. Yet, it's a huge industry. You are selling it and you are selling it based on a lack of evidence and putting workers at financial risk. Why?

ED HOWARD: Karen, do you want to weigh in?

KAREN POLLITZ: There is a link in our issue brief too, the Rand studies that looked at cost savings and also clinical health improvements from wellness programs and both findings suggested that it was very small, but then it also depended a lot on the programs design. Going back to the rule that has been proposed, Rand also noted that one in five of these wellness programs really is just about health screening. It may ask you to give a blood sample or step on a scale or answer a questionnaire about your health status and

then that is kind of it. Those programs I think have not been found to produce a lot of cost savings. They may be sort of adopted by employers as a first step to them adopt other programs or maybe just to promote sort of self-awareness. I don't really know. But those seem to be pretty popular. Under the new rules, people would -- regardless of what they do to change their health, they would have to each year face a financial incentive and decide whether or not they are going to divulge that information.

ED HOWARD: We only have six or seven minutes left and I have time for just a couple of questions that have been put on green cards. I apologize in advance if you haven't seen your question asked and you may not. I would ask that you write one more thing and that is your reaction to the program and suggestions for future programs on the blue evaluation form as we move toward the end. And I wanted to take a nugget from one of the questions and relate it, Karen, to one of your slides in which you note that for the large firm wellness programs; only 4% of them actually include a reward or a penalty. Which is also related to your notion about the screening only folks. Of those 4%, three out of five of them have incentives that are valued at \$500 a year or less. So the question is, how big of a deal is it to be argued out in litigation that some relatively small percentage of these programs carry penalties or rewards that might threaten some aspects of some workers well being. How about that for an open-ended opportunity?

KAREN POLLITZ: Well, we did ask, I think last year for the first time about the size of the incentives and we just asked a simple question, more or less than \$500 and got the results that I showed you. Not only for the health contingent programs but for incentives to complete the HRAs or to participate in a wellness program generally. This year I think we are asking a little more detailed question to try to find out for those that are above 500, how far above 500? But its safe to say that so far not that many wellness programs have gone the route of actually linking how much you pay for a premium, to achieving a certain health outcome, even though that is what the ACA has allowed now for a couple of years. The EEOC rule, concerns about how that works may be one reason why employers haven't gone this route so far. But the EEOC rule would allow these incentives for participatory programs as well. So I think we don't know yet what the result of that would be, might we see more employers adopting these health contingent wellness programs. Or might we see more employers using HRAs and financial incentives to get their employees to fill them out.

ED HOWARD: Do employers still have to make reasonable accommodations for disabled workers in incentive based programs once the EEOC rule goes into effect, assuming it does? In it's current form.

KATIE MAHONEY: Yes. Yes.

ED HOWARD: They do?

KATIE MAHONEY: Yes.

ED HOWARD: Okay, I promised you we would get back to privacy and one of our audience members asks about employee privacy in the context of rewards and penalties. That is to say, if you do not participate in this program and your premium goes up, wouldn't that show on every paycheck? That is, wellness programs at the workplace would clearly identify who is participating and who isn't. Does that vitiate the privacy protections or are there ways you can get around that? Katie, does that ring a bell at all?

KATIE MAHONEY: I don't have an answer for that, but I would love to look into it and get back to you, unless Samuel can answer it.

SAM BAGENSTOS: I think that this is one of the aspects like what Karen was talking about. Despite the privacy protects that are in the law under the ADA or HIPAA, there are lots of ways that people in workplaces can find out about information that is supposed to be private and this is one of the dots that people can use to connect. I think that is right.

ED HOWARD: Make this the last question and it's raised in several of the cards that have come forward. Is it possible to design effective wellness programs without raising some of the legal issues that professor Bagenstos and others have identified in the course of this conversation? What is really necessary in the way of incentives, if there are incentives necessary to change behavior in the ways that Dan Newton was describing?

KATIE MAHONEY: I guess my quick answer would be, I think that there are probably are. I guess I would leave it to the folks that study this, that might have more factual information to back up what I'm going to say as a general sense, which is that those programs may be much more modest in terms of the action that they encourage employees to do and take and may have much less impact on improving health status and improving health conditions. So I think it's a matter of how -- I don't want to use the word "aggressive". How strong of a program do you want to develop and how much of an impact, how much of a positive impact do you want to have on the health of your employees?

DAN NEWTON: I think even Karen and her survey kind of alluded to the specifics and again, these specifics have been around quite some time. But you really need strong leadership. If you have strong leadership in an organization that supports that focus on kind of health and wellness, you have good communication, you have a variety of programs, then incentives become diminished. There actually has been some research studies that showed the relative effect of looking at just HRA participation. So if you had the components of strong leadership and strong communication and the difference being that you would have to -- to drive the same relative effect in HRA participation, \$140 incentive could be driven with a \$40 incentive with just good communication and strong leadership. So I think you are going to find incentives over time have less than an issue. If you take the concept of consumerism, then you will create value, you will create emotion, you will get people to adopt and that will be the issue and how do we drive value, how do we get people emotionally connected to their health and incentives aren't - a lot of times its just the entry ticket and the hope is that once you get them by that entry

ticket, they will become more emotionally engaged. But I think over time it will be less of an issue particularly in the work force.

KAREN POLLITZ: The one question we did ask in our survey was to ask employers how effective they thought financial incentives are -- and employers respond that they think they are only somewhat effective for the most part. So I think that is consistent with the other survey data that both employers and employees, that people tend to participate if the program offers something that they find meaningful and its convenient and they have time and all of the other things. But even the [EBRY] survey found that those factors were more determinative of participation than financial incentives that avoiding the penalty was cited less often by people than these other program design features for why they participated.

SAM BAGENSTOS: So make the wellness programs voluntary and they will work well. You don't need to have the financial incentives. I like this answer.

ED HOWARD: My goodness, we are edging toward a consensus at the right time. And we thought there would be fireworks. Let me just remind you to take the time to fill out your evaluation if you would. This has been really illuminating, at least to me. I very much appreciate the contribution of the panel. Thanks to our colleagues at Anthem for allowing us to take another look at these programs and I know we are going to be monitoring how these regulations and how the industry practices develop over the next couple of years to try to take a closer look at the policy implications for those of you who are involved in that part of the process. Join me in thanking our panel for a very useful discussion.

[applause]

I meant to mention, a lot of the questions that were raised in the discussion are really well addressed in the materials in your packets and if you haven't had a chance to take a look at them, please do. They really are helpful in understanding what the issues are.