



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

June 19, 2015

Bernadette Wilson  
Acting Executive Officer  
U.S. Equal Employment Opportunity Commission  
131 M Street NE  
Washington DC 20507

**Re: Comments on Proposed Rule, Amendments to Regulations  
Under the Americans With Disabilities Act, RIN 3046-AB01**

The undersigned members of the Consortium for Citizens with Disabilities (CCD) submit these comments in response to the EEOC's proposed rule to modify the Americans with Disabilities Act's (ADA's) medical inquiries provisions to address workplace wellness programs. CCD is a coalition of national disability organizations working for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

We are surprised to see that, as the ADA approaches its 25<sup>th</sup> anniversary, the EEOC is proposing a rule that would significantly diminish workers' rights to keep disability-related information unrelated to their job performance out of the hands of their employers and protect themselves from discrimination. The Commission's proposed rule is inconsistent with the plain language of the ADA, and would change the Commission's longstanding interpretation of the ADA by removing important employee protections.

People with disabilities cannot afford to lose their jobs. Individuals with disabilities have the lowest employment rates of any group tracked by the Bureau of Labor Statistics. Less than 30 percent of working-age Americans with disabilities participate in the workforce, compared to over 78 percent of non-disabled Americans.<sup>1</sup> More than 28% of working-age Americans with

---

<sup>1</sup> Senate Committee on Health, Education, Labor and Pensions, *Fulfilling the Promise: Overcoming the Persistent Barriers to Economic Self-Sufficiency for People with Disabilities*, Majority Committee Staff Report 2 (Sept. 18, 2014),

disabilities live in poverty—more than twice as many as Americans without disabilities.<sup>2</sup> The Commission’s proposal to take away workplace protections and make it easier for employers to discriminate against workers with disabilities is extremely troubling.

The Commission proposes to define “voluntary” medical inquiries in an employee health program to permit penalties that would more than double what most employees pay for their health insurance if they decline to answer. This definition is so far afield from the ordinary meaning of “voluntary” that it is an invalid interpretation of the statute. *See General Dynamics Land System v. Cline*, 540 U.S. 581, 600 (2004) (no level of deference to EEOC’s rulemaking is appropriate when the Commission’s interpretation of a statute “is clearly wrong.”). The protections proposed by the Commission to mitigate the harm that might be caused by the rule are inadequate to remedy that harm.

### **I. The ADA Requires Workplace Wellness Program Medical Inquiries and Exams to be Voluntary**

The Americans with Disabilities Act (ADA) prohibits employers from subjecting employees to medical inquiries or exams that are not job-related and consistent with business necessity, unless they are “voluntary medical examinations, including *voluntary* medical histories, which are part of an employee health program available to employees at that work site.”<sup>3</sup>

For the last 15 years, the EEOC has defined “voluntary” for purposes of this provision to mean that an employer may neither require participation nor penalize employees who do not participate.<sup>4</sup> In 2009, Chair Ishimaru and Vice Chair Griffin issued a letter concluding that a wellness program that included a premium discount of 10% for filling out a health risk assessment that asks about current health status would likely violate the ADA by imposing

---

<http://www.help.senate.gov/imo/media/doc/HELP%20Committee%20Disability%20and%20Poverty%20Report.pdf> (citing Bureau of Labor Statistics data).

<sup>2</sup> *Id.* at 6.

<sup>3</sup> 42 U.S.C. §§ 12112(d)(4)(A), (d)(4)(B). *See also EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act* (July 27, 2000) at Question 22, <http://www.eeoc.gov/policy/docs/guidance-inquiries.html> (“EEOC Guidance”).

<sup>4</sup> *EEOC Guidance*, Question 22. While the guidance speaks of “voluntary wellness programs” rather than “voluntary medical inquiries” or “voluntary medical examinations,” it construes the ADA’s text relating to “voluntary medical examinations, including voluntary medical histories” that are part of an employee health program. It is clear that the guidance refers to penalties for answering questions or undergoing medical exams.

higher health insurance costs on employees who decline to answer questions about their current health status or undergo medical exams.<sup>5</sup>

The ADA's medical inquiries provisions are part of a detailed scheme that Congress enacted to limit employer access to medical information from employees and applicants. Such limits are a core protection of the ADA. Congress prohibited medical inquiries and medical exams of employees that are not job-related and consistent with business necessity in order to prevent discrimination. See S. Rep. 101-116, at 39-40 (1989) ("An inquiry or medical examination that is not job-related serves no legitimate employer purpose, but simply serves to stigmatize the person with a disability. . . . As was abundantly clear before the Committee, being identified as disabled often carries both blatant and subtle stigma. An employer's legitimate needs will be met by allowing the medical inquiries and examinations which are job-related.").

As the EEOC noted in its guidance concerning disability-related inquiries of employees:

Historically, many employers asked applicants and employees to provide information concerning their physical and/or mental condition. This information often was used to exclude and otherwise discriminate against individuals with disabilities -- particularly nonvisible disabilities, such as diabetes, epilepsy, heart disease, cancer, and mental illness -- despite their ability to perform the job. The ADA's provisions concerning disability-related inquiries and medical examinations reflect Congress's intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employers to ensure that individuals in the workplace can efficiently perform the essential functions of their jobs.<sup>6</sup>

## **II. The EEOC's New Interpretation of "Voluntary" is Inconsistent with the Statute**

The proposed rule seeks to change the EEOC's definition of what is a voluntary inquiry, allowing employers to use steep financial penalties in wellness programs to force workers to disclose sensitive medical information to their employers. Without directly saying that it is abandoning its prior position that a voluntary wellness program inquiry cannot involve penalties, the Commission does exactly that. The Commission says that it must interpret the ADA "in light of" the Affordable Care Act's provisions permitting penalties of up to 30% of an employee's health insurance premiums in certain types of wellness programs. The Commission interprets

---

<sup>5</sup> Letter of October 9, 2009 from Stuart J. Ishimaru, Acting Chair, EEOC, and Christine M. Griffin, Acting Vice Chair, to Nancy Ann DeParle, Director, White House Office of Health Reform.

<sup>6</sup> *EEOC Guidance*, General Principles.

the ADA to permit penalties<sup>7</sup> of up to the same amount on workers who decline to answer wellness program medical inquiries that the ADA requires to be voluntary.

A. *The ADA's Plain Language and the EEOC's Existing Longstanding Guidance Forbid Penalties on Medical Inquiries that are Not Job-Related*

The plain language of the ADA requires that a medical inquiry or exam that is not job-related may be asked as part of an employee health program (including a wellness program) only if it is *voluntary*.<sup>8</sup> Since 2000, the Commission has taken the position that voluntariness means that an employer may neither require workers to participate nor penalize them for not doing so.<sup>9</sup> Thus, medical questions that an employee is financially induced to answer – through penalties or rewards – are not voluntary.

This definition is consistent with the ordinary meaning of “voluntary”: “not impelled by outside influence” and “[w]ithout valuable consideration.” *Black’s Law Dictionary* (9th ed. 2009). See also *Merriam Webster Dictionary* (“unconstrained by interference” and “without valuable consideration”). Absent a statutory definition of “voluntary,” it must be construed “in accordance with its ordinary or natural meaning.” *FDIC v. Meyer*, 510 U.S. 471, 476 (1994).

The wide range of medical questions asked by wellness program health risk assessments (HRAs) and the medical exams conducted by wellness programs are not related to employees’ ability to do their jobs, and thus are not job-related and consistent with business necessity. Accordingly, the ADA requires that these questions and exams be voluntary. The EEOC’s existing guidance prohibits penalties for not answering such questions.

---

<sup>7</sup> The proposed rule applies to “incentives” that may take the form of either rewards or penalties. 80 Fed. Reg. 21660. The Affordable Care Act and its implementing regulations also treat wellness program penalties and rewards as the same. 42 U.S.C. § 300gg-4(j)(3)(A) (defining “rewards” to include “the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan”); *Final Rule, Incentives for Nondiscriminatory Wellness Programs in Group Health Plans*, 78 Fed. Reg. 33158, 33160 (June 3, 2013) (“References in the final regulations to a plan providing a reward include both providing a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and imposing a penalty (such as a surcharge or other financial or nonfinancial disincentive).”). This makes sense, as employees who choose to forego a financial inducement to participate are effectively penalized financially for not participating.

<sup>8</sup> 42 U.S.C. § 12114(d)(A), (d)(B).

<sup>9</sup> *EEOC Guidance*, Question 22.

*B. The Proposed Rule Would Permit “Voluntary” Inquiries and Exams to be Conditioned on Steep Penalties*

The Commission’s position that medical questions or exams are “voluntary” when employees incur significant financial penalties for not responding is fundamentally unsound. The proposed rule would permit penalties that, in many cases, involve thousands of dollars. The average annual premium for single coverage in 2014 was \$6,025.<sup>10</sup> Thirty percent of that amount is more than \$1,800.00 every year. For many individuals, the penalties would be larger than \$1,800. In addition, the large majority of employees – around 85 percent – contribute about 20% to 30% of the cost of their health insurance coverage.<sup>11</sup> Thus, a penalty of 30% on top of this share would more than double the cost of health insurance for most employees. Medical questions that an employee may only decline to answer if he or she agrees to pay thousands of dollars more for health insurance can hardly be called “voluntary.”

In fact, the rationale that employers have provided for the use of large financial penalties is that these penalties are necessary to boost participation in health risk assessments as few employees choose to participate of their own volition.

*C. The EEOC Has Already Defined “Voluntary” Wellness Program Inquiries to Prohibit Penalties*

The EEOC has already interpreted what constitutes a voluntary wellness program inquiry in a very similar context. The Commission promulgated a rule in 2010 to implement the Genetic Information Non-discrimination Act’s (GINA’s) parallel provisions permitting voluntary inquiries about employees’ genetic information as part of wellness programs.<sup>12</sup> That rule, using the same language from the EEOC’s ADA guidance on medical inquiries of employees, states that the GINA “wellness program” exception applies only where “the provision of genetic information is voluntary, meaning the covered entity *neither requires the individual to provide genetic information nor penalizes those who choose not to provide it.*”<sup>13</sup> The GINA regulation further clarifies that an employer “may not offer a financial inducement for individuals to provide genetic information” in a wellness program, and that any inducement for completing a health risk assessment must be offered regardless of whether an employee chooses to answer the

---

<sup>10</sup> The Kaiser Family Foundation and Health Research & Educational Trust, *2014 Employer Health Benefits Survey* (Sept. 12, 2014), at 1-2, <http://kff.org/report-section/ehbs-2014-section-one-cost-of-health-insurance>.

<sup>11</sup> *Id.* at 1-2 & Exh. B.

<sup>12</sup> 29 C.F.R. § 1635.8(b)(2).

<sup>13</sup> *Id.* § 1635.8(b)(2)(i)(A) (emphasis added).

questions about genetic information.<sup>14</sup> The ADA must be interpreted in the same way: if financial inducements are offered to employees for completing a health risk assessment, the inducements must be offered regardless of whether the employee chooses to answer questions about disability-related information.<sup>15</sup>

### **III. The ACA and HIPAA Do Not Require the Commission to Reinterpret the ADA’s Medical Inquiries Provisions**

The Commission is simply wrong in concluding that it must interpret the term “voluntary” to reflect the provisions of an unrelated law that does not supersede the ADA’s requirements. As the ACA’s implementing regulations concerning wellness programs expressly state, and the EEOC acknowledges, compliance with ACA and HIPAA rules does not determine compliance with any provision of the ADA. The mere fact that the ACA and HIPAA limit the total penalties imposed in certain types of wellness programs to 30% of an employee’s premiums does not mean that the ADA cannot impose other limitations—namely that a subset of wellness program inquiries (those that seek *medical* information) must not penalize workers who decline to answer.

#### *A. The ADA does not bar conduct expressly authorized by the ACA and HIPAA*

The ACA and HIPAA do not require or expressly authorize wellness programs to impose penalties for not answering medical questions. What they expressly authorize—total wellness program penalties of up to 30% of employee premiums in certain wellness programs—is not precluded by the ADA. It is not difficult for employers and wellness plans to comply with both the ACA/HIPAA and the ADA; compliance with both laws does not require a reinterpretation of the ADA.

Notwithstanding its position that it must import the ACA’s “30% rule” into the ADA’s provisions concerning medical inquiries in order to “conform” its interpretation of the ADA to the ACA’s wellness program provisions, the Commission’s application of the 30% rule does *not* conform to the ACA’s 30% rule. It is different in a number of respects. For example:

- the ACA’s 30% incentive cap applies only to health-contingent wellness programs<sup>16</sup> whereas the proposed ADA rule’s 30% cap extends to all wellness programs, including participatory programs;

---

<sup>14</sup> *Id.* § 1635.8(b)(2).

<sup>15</sup> Just as this rule is feasible under GINA because not all health risk assessment questions seek genetic information, the same is true under the ADA, since not all health risk assessment questions seek disability-related information. For example, typical HRAs may ask questions about whether a person uses sunscreen, eats whole grain foods, wears a seatbelt, exercises, watches television, drives within the speed limit, takes precautions to avoid workplace accidents, wears hats, avoids tanning booths and sunlamps, attends plays and concerts, and many other questions that do not relate to whether the person has a disability.

<sup>16</sup> 42 U.S.C. § 300gg-4(j)(3)(A).

- the ACA’s cap is 30% of employee-only insurance premiums or, if the individual’s family members participate in the wellness program, 30% of family coverage,<sup>17</sup> whereas the proposed ADA rule’s 30% cap is for employee-only coverage (average premium amounts for family coverage are approximately \$16,000 per year in 2014, in contrast to \$6,000 per year for employee-only coverage);
- the ACA’s cap on penalties for wellness programs with tobacco cessation programs is 50%,<sup>18</sup> whereas the proposed ADA rule applies a 30% cap on incentives for answering medical inquiries in such programs.

The Commission’s own recognition that the ACA does *not* require it to import the ACA’s wellness penalty rules into the ADA undermines the argument that the ACA left the Commission no choice but to adopt the proposed rule. Indeed, if the Commission believes that the ACA requires it simply to use a “30%” figure in determining permissible penalties for not answering medical questions, it could as easily limit the penalty cap to 30% of the employee’s own share of health insurance premiums; such an amount would be far less onerous than 30% of the total employee premiums.

*B. The ACA and HIPAA Regulations Concerning Wellness Programs Explicitly State that the ADA’s Confidentiality Provisions Apply Simultaneously*

The 2006 regulations from the Departments of Treasury, Labor, and Health and Human Services implementing HIPAA explicitly recognize that the ADA imposes separate, additional restrictions on wellness programs.<sup>19</sup> And the 2015 “Tri-Agency” ACA regulations reiterate this interpretation of the three statutes:

[T]hese final regulations are implementing *only* the provisions regarding wellness programs in the Affordable Care Act. Other State and Federal laws may apply with respect to the privacy, disclosure, and confidentiality of information provided to these programs. For example . . . employers subject to the Americans with Disabilities Act of 1990 (ADA) *must comply with any applicable ADA requirements for disclosure and confidentiality of medical information and non-discrimination on the basis of disability.*<sup>20</sup>

---

<sup>17</sup> *Id.*

<sup>18</sup> 26 C.F.R. § 54.9802-1(f)(5).

<sup>19</sup> See 71 Fed. Reg. 75014, 75015 (2006).

<sup>20</sup> 78 Fed. Reg. 33158, 33165 (emphasis added).

...

Compliance with the HIPAA nondiscrimination rules (which were later amended by the Affordable Care Act), including the wellness program requirements in paragraph (f), is *not determinative of compliance with any other provision of ERISA, or any other State or Federal law, including the ADA*. This paragraph is unchanged by these final regulations and remains in effect. As stated in the preamble to the 2006 regulations, the Departments recognize that *many other laws may regulate plans and issuers in their provision of benefits to participants and beneficiaries*. These laws include, but are not limited to, the ADA, Title VII of the Civil Rights Act of 1964, Code section 105(h) and PHS Act section 2716 (prohibiting discrimination in favor of highly compensated individuals), the Genetic Information Nondiscrimination Act of 2008, the Family and Medical Leave Act, ERISA's fiduciary provisions, and State law.<sup>21</sup>

*C. The ACA and HIPAA wellness penalty provisions address insurance discrimination and not employment discrimination*

The provisions in the ACA and HIPAA wellness program penalties address when such penalties constitute *insurance* discrimination.<sup>22</sup> They do not address the separate concern of when such penalties, used in an employer-sponsored wellness program, have the effect of discriminating in *employment*. The ADA defines employment discrimination to include subjecting employees to medical inquiries and exams that are not job-related and not voluntary. While it may not be insurance discrimination to impose penalties below a certain level on employees' failure to answer non-job related medical inquiries and exams, it is employment discrimination under the ADA.

*D. The ACA and HIPAA did not repeal the ADA by implication*

The wellness provisions in the ACA and HIPAA do not repeal by implication the ADA's medical inquiries provisions. If Congress meant to repeal the wellness program requirements of the ADA, it would not have done so without saying anything. There is nothing in the ACA or HIPAA indicating Congressional intent to repeal the ADA's medical inquiries provisions, and repeals by implication are disfavored.<sup>23</sup>

---

<sup>21</sup> *Id.* at 33168 (emphasis added).

<sup>22</sup> Since its passage in 1996, HIPAA has barred discrimination by group health plans in coverage and premiums "based on" one of eight "health status-related factors," including "health status," "medical condition" (including both physical and mental illnesses), and "disability." Public Law 104-191 (Aug. 21, 1996). The ACA expanded these HIPAA non-discrimination protections to include individual health insurance plans. *See* Public Law 111-148 (Mar. 23, 2010), § 2705(a); 42 U.S.C. § 300gg-4(a).

<sup>23</sup> *Morton v. Mancari*, 417 U.S. 535, 550 (1974).

The fact that two statutes regulate the same conduct and impose different rules does not mean that one repeals the other by implication; “as long as people can comply with both, then courts can enforce both.”<sup>24</sup> The ADA and HIPAA/ACA are capable of coexistence, and it is possible to comply with both simultaneously. The ADA’s medical inquiries provisions do not bar employers from imposing the penalties of up to 30% of employee premiums permitted by the ACA/HIPAA in health-contingent wellness programs. They permit employers to impose penalties of that amount in order to induce employees to participate in wellness program services, meet health targets, and/or participate in health risk assessments, as long as they offer reasonable accommodations and avoid penalizing employees for failing to answer those health risk assessments that seek medical information or undergo medical exams.

It is routine for two laws that apply to the same conduct to impose independent obligations, and one statute may impose greater or different obligations than the other. For example, the Medicaid Act expressly permits states to limit the number of Medicaid recipients they serve under home and community-based services waiver programs, but the ADA’s integration mandate may require states to seek an increase in the waiver “cap” in order to avoid needlessly institutionalizing people with disabilities. *See* United States Dep’t of Justice, *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C., Questions and Answers on the ADA’s Integration Mandate and Olmstead Enforcement, Question 7* [http://www.ada.gov/olmstead/q&a\\_olmstead.pdf](http://www.ada.gov/olmstead/q&a_olmstead.pdf). *See also* *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999).

The IDEA and ADA also impose independent obligations. *See, e.g.*, Statement of Interest of the United States of America in *S.S. v. Springfield Public Schools*, Civ. Action No. 3:14-cv-30116, at 2, available at [www.ada.gov/briefs/springfield\\_ma\\_soi.pdf](http://www.ada.gov/briefs/springfield_ma_soi.pdf) (“ . . . while the ADA and IDEA provide complementary protections for many students with disabilities, they are not identical in purpose or scope and impose distinct obligations on school districts in furtherance of their respective statutory mandates. . . . [the ADA] may require different or additional measures to avoid discrimination against children with disabilities than the measures that are required to comply with IDEA.”).

*E. Conclusion: The Commission Should Continue to Bar Penalties on Employees for Not Participating in Wellness Program Medical Exams and Inquiries*

For the reasons described above, the Commission should continue to interpret the ADA’s requirement that wellness program medical exams and inquiries that are not job-related be “voluntary” to bar penalties for failure to participate in such exams and inquiries. The Commission should specify that this requirement is to be implemented in the same way as the parallel requirement in GINA: if financial inducements are offered to employees for completing

---

<sup>24</sup> *Randolph v. IMBS, Inc.*, 368 F.3d 726, 730 (9th Cir. 2004).

a health risk assessment, the inducements must be offered regardless of whether the employee chooses to answer questions about medical information.<sup>25</sup>

#### **IV. The Commission's Proposed Protections are Inadequate to Prevent the Rule from Causing Harm**

In order to mitigate the harms that may be caused by its proposed rule, the Commission proposes requiring written notice of information being sought by health risk assessments and a confidentiality rule limiting the transmission to employers of individually identifiable information gleaned through wellness program medical inquiries. In the event that the Commission adopts its proposed interpretation of the ADA's medical inquiries provisions, we urge the Commission to strengthen these protections, as they are inadequate to prevent employees from being harmed.

##### *A. The Proposed Notice Requirement is Insufficient*

The proposed rule requires that a wellness program that is part of a group health plan and asks medical questions must provide written notice describing the type of medical information that will be sought and the specific purposes for which it will be used, the restrictions on disclosure of the medical information, the employer representatives or third parties with whom it will be shared, and the methods used to prevent improper disclosure.

While such notice is helpful and we urge the Commission to require it if it adopts its proposed "30% rule," it does not eliminate the primary problem created by the proposed rule. Providing employees with notice of exactly what the Hobson's choice is that they will face does not eliminate the fact that they are given a Hobson's choice (turn over sensitive medical information or pay steep financial penalties).

The EEOC solicits feedback on whether notice requirements should also require plans to seek prior, written, and knowing confirmation from employees that their participation is voluntary. Such a requirement would only be meaningful if an employee's indication that his or her participation is not voluntary would enable the employee to receive the reward, or avoid the penalty, without filling out the health risk assessment (or without filling out the medical

---

<sup>25</sup> Just as this rule is feasible under GINA because not all health risk assessment questions seek genetic information, the same is true under the ADA, since not all health risk assessment questions seek disability-related information. For example, typical HRAs may ask questions about whether a person uses sunscreen, eats whole grain foods, wears a seatbelt, exercises, watches television, drives within the speed limit, takes precautions to avoid workplace accidents, wears hats, avoids tanning booths and sunlamps, attends plays and concerts, and many other questions that do not relate to whether the person has a disability.

questions on the assessment). Otherwise, the written confirmation would not serve any purpose; if an employee feels pressured into filling out a health risk assessment, the employee will feel the same pressure to indicate that his or her participation is voluntary if to do otherwise would mean losing the reward or incurring the penalty. We strongly urge the Commission to require notice that permits employees who indicate that their participation is not voluntary to avoid the penalty (or receive the reward) without filling out the health risk assessment.

*B. The Proposed Confidentiality Requirements are Insufficient*

The confidentiality protections included in the proposed rule are inadequate to remedy the problems created by the Commission's misinterpretation of the ADA. The proposed rule references already-existing HIPAA confidentiality obligations that apply to group health plans operating wellness programs. In addition, the proposed rule would bar the provision to an employer of individually identifiable information collected by wellness program medical exams and inquiries "except as necessary to administer the plan." If the Commission adopts its proposal to allow penalties up to 30% of employee premiums, at a minimum, it should expand these confidentiality protections to minimize the harm created by such penalties.

First, the Health Insurance Portability and Accountability Act (HIPAA) protections referenced by the Commission do not apply employers, but only to the health plans operating the wellness programs. If these plans violate HIPAA by disclosing information to employers, workers have no recourse against their employers. Moreover, HIPAA's privacy protections are not privately enforceable. Individuals whose health information is impermissibly disclosed can file an administrative complaint with the Office for Civil Rights (OCR) in the Department of Health and Human Services (HHS). But OCR/HHS enforces compliance in only a tiny number of complaints and often takes more than a year to resolve complaints. Among the more than 115,000 HIPAA complaints OCR had received as of two months ago, it had initiated only 1,214 compliance reviews. Department of Health and Human Services, "Enforcement Highlights (As of April 30, 2015)," (available at [www.hhs.gov/ocr/privacy/hipaa/enforcement/highlights/index.html](http://www.hhs.gov/ocr/privacy/hipaa/enforcement/highlights/index.html)). And "[f]rom the 2003 compliance date of the HIPAA Privacy Rule through the end of calendar year 2012, out of all the cases OCR attempted to resolve informally a resolution agreement, only one case resulted in the imposition of a CMP [civil monetary penalty]." Department of Health and Human Services, "Annual Report to Congress on HIPAA Privacy, Security, and Breach Notification Rule Compliance," at 6 (Calendar Years 2011 and 2012) (available at [www.hhs.gov/ocr/privacy/hipaa/enforcement/compliancereport2011-2012.pdf](http://www.hhs.gov/ocr/privacy/hipaa/enforcement/compliancereport2011-2012.pdf)). Finally, some health risk assessment web sites include a provision, buried in an obscure link, stating that using the wellness program web site constitutes a waiver of the person's privacy rights; if such waivers are effective, HIPAA offers no protection.

The proposed rule purports to protect employee medical information from employers by adding a requirement that information obtained by an employee health program, through its medical

inquiries or exams, “regarding the medical information or history of any individual may only be provided to an ADA covered entity in aggregate terms that do not disclose, or are not reasonably likely to disclose, the identity of any employee.” See §1630.14(d)(6). First, it is unclear that this requirement actually applies to any covered entities; if it does not, it is meaningless. The obligation that it imposes appears to be directed at wellness plans that are not covered entities under the ADA and thus need not comply with ADA regulations.<sup>26</sup> The obligation should be on the *employer* not to *collect or receive* this information.

Second, wellness programs create opportunities for employers to discover an employee’s identity and disability through other means than the program disclosing this information directly to an employer. For example, employers may be able to individually identify an employee with a disability when the wellness program directs an employee to attend a worksite-based “employee assistance program” (EAP), or when the wellness program discloses employees’ medical information to third parties who, based on that information, may market specific products and services to the employee through his or her work email, intranet, postal mail or telephones.

In addition, for employees of small employers or at small worksites, aggregate data collection will not ensure that a disability is not disclosed to employers – an employee who is the only member of a 15-employee firm who has diabetes, and who is known at work for carefully tracking what and when he eats, may be effectively disclosing his disability to any supervisor who looks at “aggregated” wellness program data.

To ensure that confidentiality of employees’ medical information is better protected, the EEOC should require that employee medical information from health risk assessments is not gathered on or stored on workplace computers or servers, or in paper files kept in the workplace. The EEOC should require that wellness marketing and other communications are not transmitted through work email, intranet, postal mail or telephones. And the EEOC should require the steps described in its Interpretive Guidance, *see* Appendix to Part 1630 regarding Section 1630.14(d)(4)-(6), including that employers adopt clear privacy policies (including prohibiting wellness programs from seeking waivers of privacy rights with respect to medical information furnished by employees where employees are penalized for not providing this information) and train employees to protect private information; not allow employees who have access to coworkers’ medical information to make employment decisions impacting those coworkers; and encrypt electronically-stored medical information. We strongly object to the Commission’s

---

<sup>26</sup> Insurance plans generally are not covered entities under Title I of the ADA. *See, e.g., Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1113 (9th Cir. 2000) (insurance company was “simply the administrator of the employer’s disability policy” and not a “covered entity” under Title I); *McMillian v. General Elec. Co.*, Civil Action No. 09-160, 2010 WL 3672243, at \*4 (E.D.N.C. Jul. 12, 2010), *report and recommendation adopted* 2010 WL 3732141 (insurance company not considered employer for purposes of ADA); *Good v. Blue Cross and Blue Shield of Maryland, Inc.*, Civil Action No. 96-2843, 1996 WL 815373, at \*1 (D. Md. Nov. 19, 1996); *Pappas v. Bethesda Hosp. Ass’n*, 861 F. Supp. 616, 619 (S.D. Ohio 1994) (administrator of employee benefits not employer under ADA).

description of these steps as “best practices” rather than requirements. The term “best practices” serves as nothing more than an indication that these steps need not be undertaken.

The proposed rule also contains an exception to the bar on transmission of individually identifiable data where the employer needs individually identifiable information “to administer the health plan.” We believe the exception is inappropriate and urge the Commission to eliminate it; individually identifiable medical information should not be necessary to “administer” a wellness program. If the Commission retains the exception, it should be clearly defined and narrow in scope. For example, the fact that a wellness program has referred an employee to a counseling program that requires the employee to leave work early one day per week does not mean that the employer needs that worker’s mental health information. In addition, the Commission should clarify that the exception is intended to apply only where an employer is administering a wellness program itself rather than contracting with a third party wellness program vendor. And the Commission should provide that employers who choose to administer their own wellness plans may not use penalties or rewards to induce employees to answer medical questions or medical exams as part of those plans.

## **V. Additional Issues on Which EEOC Seeks Feedback**

### *A. The Doctor Certification about which the Commission Solicits Feedback Should be Included and Strengthened in the Final Rule*

The proposed rule solicits feedback on whether, for medical questions tied to financial incentives to be “voluntary,” employees must be offered similar incentives if they choose not to answer but instead provide certification from a medical professional stating that the employee is under the care of a physician and that any medical risks identified by that physician are under active treatment.

Permitting employees to avoid penalties by showing that they are already receiving care for any condition asked about by a health risk assessment would be an important reasonable accommodation, and the Commission should include this protection in the final rule. However, this avenue may not offer equal opportunity to employees with disabilities. First, certifications from specialty doctors, such as a psychiatrist, a heart doctor, or a liver specialist, would reveal information about the nature of an employee’s medical conditions and undermine the very purpose of avoiding answering the questions. It would be unwieldy and impose onerous burdens if the form required confirmation from all of the doctors treating an individual for various conditions or symptoms inquired about by the assessment. Moreover, many treating professionals would charge an employee for an evaluation in order to submit a certification. Particularly with multiple treating professionals involved, such charges may be prohibitively expensive for many employees. Additionally, many professionals will simply fail or refuse to submit certifications at all.

The Commission should clarify that the certification need only be submitted by a single health professional who may be a treating specialist or a primary care physician (or other professional such as a nurse practitioner or social worker) who is familiar with the worker's health profile, and who confirms based on the representations of the individual that he or she does not have the health risks inquired about in the health risk assessment or that any health risks that may have been identified are being managed, and that the health professional may submit the certification without letterhead if the letterhead would reveal information about the patient's medical issues (such as an oncology practice).

Finally, the notion of "active treatment" reflects a misunderstanding of appropriate monitoring for many health conditions. For many people who face medical risks due to a health condition, the appropriate course of action is not to provide "active treatment" such as medication, therapies, or other interventions but simply to monitor the person's condition on a regular basis and to intervene only if there is a particular reason to do so. The Commission should delete this language.

*B. The Protection Concerning Unaffordability of Health Insurance Should be Included and Strengthened*

The proposed rule solicits feedback on whether, for wellness program medical questions or exams to be voluntary, incentives imposed to encourage employees to answer or to be examined must not be so large as to render health insurance unaffordable according to the ACA's standards. It would be ironic indeed if the answer to this question could be no—that is, that medical questions or exams in an employee *health* program could be voluntary even if they are tied to penalties so large as to make health insurance coverage unaffordable to employees if they decline to answer the questions or undergo the exams.

While we think the answer must be that such penalties render questions and exams involuntary, whether a person can afford health insurance is not the sine qua non of whether such questions and exams are voluntary. When financial penalties are used to pressure individuals to answer medical questions or undergo exams, those questions or exams are not voluntary, even if the person can still afford health insurance. If the Commission adopts its proposed "30% rule," it should include a protection for low-income employees, but the threshold for when penalties must be avoided should be far lower than the ACA unaffordability standard.

*C. Other methods for implementing the intent of the ADA's "voluntary requirement" and the ACA's wellness program provisions*

The Commission solicits feedback on whether there are any other methods by which it could implement the intent of the "voluntary" requirement and the provisions in the ACA intended to encourage workplace health promotion and disease prevention. As noted in our comments, the EEOC could use the same approach as it did in interpreting GINA's requirement that wellness program inquiries about genetic information be voluntary: identify those health risk assessment

questions that seek medical information and inform employees that they need not answer those questions in order to receive the reward for filling out the health risk assessment.

*D. Practices to ensure that wellness programs are designed to promote health and do not operate to shift costs to employees with health impairments or stigmatized conditions*

The Commission solicits feedback on practices that ensure that wellness programs are designed to promote health and do not operate to shift costs to employees with health impairments or stigmatized conditions. We point the EEOC to the findings of the RAND study sponsored by the Departments of Labor and HHS. This study found that well designed wellness programs succeed in promoting employee participation without the use of incentives. The study notes that comprehensive programs with genuine corporate and manager engagement in wellness and commitment to monitoring and evaluating programs tend to succeed. By contrast, limited programs, such as HRA-only programs, tend not to inspire participation without use of incentives and tend not to reduce costs or improve health.<sup>27</sup>

We urge the Commission to require that, to be a “reasonably designed wellness program,” a program must offer *services* beyond simply telling employees to follow up on potential health risks. The Commission’s proposed rule would appear to permit wellness programs that are effectively HRA-only programs to solicit employees’ medical information. We do not believe Congress intended the “employee health program” exception to the ADA’s medical inquiries provision to encompass programs that do not actually provide any health service other than suggesting that employees follow up on any potential health risks; such a rule would allow the exception to swallow the rule by affording employers *carte blanche* to ask workers all manner of medical questions without actually offering any health program services that benefit the workers.

We also urge the Commission to require that, to be “reasonably designed,” a wellness program must have a solid evidence base demonstrating that the program—including any penalties or rewards that it imposes—results in significant improvement in employees’ health and significant reductions in health care costs. The principal author of the federal government-sponsored RAND study, the lead study on wellness program effectiveness, stated:

Why do employees, and in particular those at high risk, choose not to participate? We do not yet have the evidence or insight to understand and convincingly answer that question. When we do, we will be able to design attractive and accessible programs. In

---

<sup>27</sup> Soeren Mattke et al., RAND Health, Workplace Wellness Programs Study: Final Report (2013), <https://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf>.

the meantime, *we should not penalize vulnerable employees who are reluctant to join marginally effective programs.*<sup>28</sup>

*E. Whether employers offer wellness programs outside of a group health plan and whether the ADA should limit the use of incentives in those programs.*

According to the Kaiser Family Foundation, nearly half of large employer wellness programs – and more than half of very large employer wellness programs (those with more than 5000 workers) say they are offered outside of the group health plan.<sup>29</sup> The Commission’s rationale for its proposed reading of the ADA’s “voluntary” medical inquiries requirement in group health plan wellness programs is an asserted need to conform the ADA to the ACA/HIPAA provisions concerning wellness program penalties. For wellness programs outside of group health plans, there is no need to conform the ADA to the ACA and HIPAA, as the relevant provisions of those laws apply only to group health plans, and thus there is no need to conform the ADA to the ACA/HIPAA with respect to wellness programs outside of group health plans. It would add insult to injury to permit the use of penalties to pressure employees to answer “voluntary” medical questions when there is not even an applicable ACA/HIPAA provision that the Commission claims is in conflict with the ADA’s medical inquiries requirement. For these wellness programs, the Commission should retain its existing rule and disallow penalties for failure to answer medical inquiries or take medical exams.

**VI. The Commission Should Specify that Waiver of Wellness Program Penalties May be Required as a Reasonable Accommodation in order to Ensure Equal Opportunity for Workers with Disabilities**

While the preamble briefly discusses the ADA’s reasonable accommodation requirement, the text of the proposed rule says nothing about this requirement. For some employees with disabilities, waiver of wellness program penalties for failure to answer medical inquiries and/or failure to participate in wellness program services is a necessary reasonable accommodation to ensure equal employment opportunity. Some of the examples provided in the comments submitted by groups representing individuals with eating disorders highlight the need for waiver of penalties to ensure that employees with disabilities are treated equally; for many of these individuals, wellness programs are not only ill-suited to meet their health needs but cause harm. The EEOC should specify that waiver of penalties (or rewards) may be required as a reasonable

---

<sup>28</sup> Soeren Mattke, *When It Comes To The Value Of Wellness, Ask About Fairness Not Just About Effectiveness*, Health Affairs Blog (Mar. 18, 2015), <http://healthaffairs.org/blog/2015/03/18/when-it-comes-to-the-value-of-wellness-ask-about-fairness-not-just-about-effectiveness/>.

<sup>29</sup> Kaiser Family Foundation, *2014 Employer Health Benefits Survey, Section 12: Wellness Programs and Health Risk Assessments* (Sept. 10 2014), <http://kff.org/report-section/ehbs-2014-section-twelve-wellness-programs-and-health-risk-assessments/>.

accommodation. The EEOC should also state that the ADA's prohibition on disability-based discrimination in the terms and conditions of employment also apply to wellness programs.

The EEOC should also state that the ADA's prohibitions on disability-based discrimination in the terms and conditions of employment also apply to wellness programs. For example, some programs base rewards or penalties on biometric screening outcomes that are coextensive with or directly related to a disability, such as blood glucose levels that separate individuals who have diabetes from individuals who don't. Wellness programs that charge higher premiums or penalize individuals because they cannot meet a program standard directly tied to their disability discriminate against those individuals in the terms of their employment. In such cases, the ADA imposes more than an obligation to accommodate; it forbids employers from imposing a penalty that is based directly on the existence of a disability.

Sincerely,

American Association of People with Disabilities  
2013 H Street, NW, 5th Floor  
Washington, DC 20006

American Association on Health and Disability  
110 North Washington Street  
Rockville, MD 20850

ACCSES  
1501 M Street NW, 7th Floor  
Washington, D.C. 20005

American Diabetes Association  
1701 North Beauregard Street  
Alexandria, VA 22311

American Foundation for the Blind  
1660 L Street NW, Suite 513  
Washington, DC 20036

The Arc of the United States  
1825 K Street NW Suite 1200  
Washington, DC 20006

Association of University Centers on Disabilities  
1100 Wayne Avenue, Suite 1000  
Silver Spring, MD 20910

Autistic Self Advocacy Network  
P.O. Box 66122  
Washington, DC 20035

Bazelon Center for Mental Health Law  
1101 15<sup>th</sup> Street NW, Suite 1212  
Washington DC 20005

Christopher and Dana Reeve Foundation  
636 Morris Turnpike, Suite 3A  
Short Hills, NJ 07078

Disability Rights Education and Defense Fund  
3075 Adeline Street, Suite 210  
Berkeley, CA 94703

Easter Seals  
1425 K Street, Suite 200  
Washington, DC 20005

Epilepsy Foundation  
8301 Professional Place East, Suite 200  
Landover, MD 20785-2353

Mental Health America  
2000 N Beauregard St #600  
Alexandria, VA 22311

National Alliance on Mental Illness  
3803 North Fairfax Drive  
Arlington, VA 22203

National Association of Councils on Developmental Disabilities  
1825 K Street NW, Suite 600  
Washington, DC 20006

National Association of State Head Injury Administrators  
PO Box 878  
Waitsfield, Vermont 05673

National Council on Independent Living  
2013 H St. NW, 6th Floor  
Washington, D.C. 20006

National Disability Rights Network  
820 1st Street NE, Suite 740  
Washington, DC 20002

National Down Syndrome Society  
666 Broadway, 8th Floor  
New York, New York, 10012

National Multiple Sclerosis Society  
1100 New York Ave., NW  
Washington, DC 20005

Paralyzed Veterans of America  
801 18th Street NW  
Washington, DC 20006

Parent to Parent USA  
2030 M St. NW, Suite 350  
Washington DC 20036

United Spinal Association  
1660 L Street NW, Suite 504  
Washington, DC 20036

VetsFirst  
1660 L Street NW  
Washington, DC 200036