January 25, 2013

Amy Turner
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

Re: Notice of Proposed Rulemaking of Department of Labor Employee Benefits Security Administration, RIN 1210-AB55, Department of Treasury Internal Revenue Service, RIN 1545-BL07, and Department of Health & Human Services Centers for Medicare & Medicaid Services, RIN 0938-AR48, concerning Incentives for Nondiscriminatory Wellness Programs in Group Health Plans.

Dear Ms. Turner:

The undersigned members of the Consortium for Citizens with Disabilities (CCD) submit these comments in response to the Notice of Proposed Rulemaking published on November 26, 2012 by the Employee Benefits Security Administration, the Internal Revenue Service, and the Centers for Medicare and Medicaid Services to implement the Affordable Care Act's provisions concerning non-discrimination in workplace wellness programs. The Consortium for Citizens with Disabilities is a coalition of national disability-related organizations working together to advocate for national public policy that ensures full equality, self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

While we believe that wellness programs can be useful tools to promote health and well-being, we have grave concerns about the potential of wellness programs to discriminate against individuals with disabilities. As you know, the employment rate of people with disabilities is far lower than that of any other group tracked by the Bureau of Labor Statistics, and people with disabilities have been disproportionately impacted by the economic downturn. Against this backdrop, we are concerned that promoting employer-based health programs which penalize people with disabilities for not being as "well" as others – and for failing to disclose disability-

related information that the Americans with Disabilities Act permits them to keep confidential in order to avoid discrimination – sends the wrong message and makes it even more difficult for individuals with disabilities to obtain employment on fair and equal terms.

We appreciate some of the protections that the Departments of Labor, Treasury, and Health and Human Services have included in the proposed rule and believe that those protections will help prevent discrimination against people with disabilities in workplace wellness programs. More protections are needed, however. And most importantly, it is critical that the final rule makes clear that wellness programs must also comply with requirements and prohibitions of the Americans with Disabilities Act (ADA).

1. The Proposed Regulations Contain Useful Protections for Health-Contingent Wellness Programs, But More Protections are Needed.

Reasonable alternative standard: The proposed rule requires health-contingent wellness programs (those that require an individual to satisfy a standard related to a health factor to obtain a reward) to allow a "reasonable alternative standard," or waiver of the otherwise applicable standard, for obtaining the reward where (1) a person's medical condition makes it "unreasonably difficult" to satisfy the otherwise applicable standard, or (2) it is "medically inadvisable" for the person to attempt to satisfy that standard. 26 C.F.R. § 54.9802-1(f)(3)(iii)(A)(1), (2); 29 C.F.R. § 2590.702(f)(3)(iii)(A)(1), (2); 45 C.F.R. §§ 146.121(f)(3)(iii)(A)(1), (2), 147.110(f)(3)(iii)(A)(1), (2).

a) Unreasonably difficult: The proposed rule does not provide any guidance concerning the circumstances under which a person's medical condition makes it "unreasonably difficult" to meet a health standard. We are concerned that this phrase may be interpreted to impose an unduly onerous standard for individuals to meet in order to receive an alternative standard or waiver. Some may misinterpret this standard as requiring an employee to prove that it is *impossible* to meet an employment health standard, or insist that the health standard must be met because the employee can perform a required measurement, test or screening in the moment, regardless of the resulting physical or psychological impact, such as extreme fatigue or the onset of a migraine, once the task is done.

The final rule should clarify that "unreasonably difficult" means that the person's medical condition would make it more difficult for the person to meet the standard than it would be for most people without that condition, as determined by his or her treating professional. This standard is consistent with the ADA's requirement that individuals with disabilities receive equal opportunity in fringe benefits and any other terms, conditions, or privileges of employment. *See* 42 U.S.C. § 12112(a)-(b); 29 C.F.R. § 1630.4(a).

If the agencies decline to interpret this standard consistent with the ADA, they must make clear that the ADA also applies to wellness programs and requires reasonable

accommodations, including alternative health standards in health-contingent programs, to ensure equal opportunity for individuals with disabilities. *See infra* at 5-9.

b) Waiver of the standard: The proposed rule does not make it clear when waiver of an otherwise applicable standard is required. The final rule should clarify that waiver of a standard is appropriate whenever the person's treating professional determines that the person's condition or disability would make it unreasonably difficult to meet a health standard or would make it inadvisable for the person to try to meet the standard and, due to a medical condition or disability, there is not an appropriate alternative standard that the person can meet.

c) Which medical professional decides: The proposed rule provides that if the reasonable alternative standard consists of "compliance with the recommendations of a medical professional who is an employee or agent of the plan, and an individual's personal physician states that the plan's recommendations are not medically appropriate for that individual, the plan must provide a reasonable alternative standard that accommodates the recommendation of the individual's personal physician with regard to medical appropriateness." 26 C.F.R. § 54.9802-1(f)(3)(iii)(B)(3); 29 C.F.R. § 2590.702(f)(3)(iii)(B)(3); 45 C.F.R. §§ 146.121(f)(3)(iii)(B)(3), 147.110(f)(3)(iii)(B)(3).

We support this provision and believe it is critical to ensure that wellness plans defer to the judgment of an individual's treating professional. However, the final rule should use the term "treating professional" rather than "personal physician." In many cases, the professional who treats the individual and is familiar with the individual's medical condition or disability will be a licensed professional other than a physician – for example, a social worker or psychologist.[1] The rule should recognize that these treating professionals, rather than solely physicians, are appropriate decision-makers.

Additionally, the final rule should make clear that the program must defer to the person's treating professional with respect to determinations that it would be unreasonably difficult for the person to meet a health standard as well as determinations that it would be medically inadvisable for the person to try to meet such a standard.

d) Making alternative programs available: The proposed rule provides that if the reasonable alternative standard is completion of an educational program, the plan must make the educational program available instead of requiring an individual to find such a program unassisted. 26 C.F.R. § 54.9802-1(f)(3)(iii)(B)(1); 29 C.F.R. § 2590.702(f)(3)(iii)(B)(1); 45 C.F.R. §§ 146.121(f)(3)(iii)(B)(1), 147.110(f)(3)(iii)(B)(1). The rationale for this proposal applies equally to other types of programs – not just educational programs – that may be

[1] *See* EEOC Enforcement Guidance: Reasonable Accommodation and Undue Hardship Under the Americans with Disabilities Act at ¶ 6 (October 17, 2002) (noting that "[a]ppropriate professionals include, but are not limited to, doctors (including psychiatrists), psychologists, nurses, physical therapists, occupational therapists, speech therapists, vocational rehabilitation specialists, and licensed mental health professionals.")

reasonable alternative standards. Hence the final rule should broaden this provision to apply to completion of any type of program rather than simply an educational program (such as a counseling program, for example). The final rule should also specify that the plan must offer a choice of programs, and must also accept as a reasonable alternative completion of a similar program identified by the individual.

e) **Paying for alternative programs:** The proposed rule provides that the plan must pay for the cost of an alternative that is an educational program, and for membership or participation fees of an alternative that is a diet program. 26 C.F.R. §§ 54.9802-1(f)(3)(iii)(B)(1), (2); 29 C.F.R. §§ 2590.702(f)(3)(iii)(B)(1), (2); 45 C.F.R. §§ 146.121(f)(3)(iii)(B)(1), (2), 147.110(f)(3)(iii)(B)(1), (2). Again, the final rule should broaden these provisions to require the plan to pay for the cost of an alternative standard that involves completion of *any* type of program (such as a counseling program, for example).

Reasonably designed: The proposed rule requires that health-contingent wellness programs be "reasonably designed to promote health or prevent disease," and designates a program as "reasonably designed" if it "has a reasonable chance of improving the health of, or preventing disease in, participating individuals and is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease." 26 C.F.R. § 54.9802-1(f)(3)(iv); 29 C.F.R. § 2590.702(f)(3)(iv); 45 C.F.R. §§ 146.121(f)(3)(iv), 147.110(f)(3)(iv). Given the narrow interpretation of the word "subterfuge" by some courts,[2] as well as the vagueness of the phrase "promote health or prevent disease," we respectfully suggest a clearer and more specific definition, namely, that a program is "reasonably designed" if it:

> has a reasonable chance of improving the health of, preventing disease in, or avoiding or slowing the progression of an existing condition in participating individuals and is not overly burdensome, does not intend disparate treatment of or have a disparate impact on individuals with disabilities, and is based on the most current medical knowledge and the best available objective evidence.

We also recommend that, in order to ensure consistency with the anti-discrimination mandate of the ADA, the final rule clarify that any marker or health outcome that defines a disability (for example, high glucose levels that are a marker for diabetes) should not be utilized as a health target or standard in any "reasonably designed" health-contingent wellness program. Such standards could be used as a proxy for disability-based discrimination and to charge employees higher insurance premiums simply because they have a disability covered by the ADA.

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[2] *See, e.g., Ohio Public Employees Retirement System v. Betts*, 492 U.S. 158 (1989) (holding that a plan could not be a "subterfuge" for discrimination as that term is used in the Age Discrimination in Employment Act where the plan existed prior to the enactment of the ADEA, and proof of "subterfuge" under the ADEA required showing an intent to discriminate); *Leonard F. v. Israel Disc. Bank of New York*, 199 F.3d 99, 104 (2d Cir. 1999) (same with regard to the ADA, citing *Betts*).

Notice: The proposed rule provides that, in all plan materials describing the terms of the program, the plan must provide notice of the availability of other means of qualifying for the reward or the possibility of waiver of the otherwise applicable standard. 26 C.F.R. § 54.9802-1(f)(3)(v); 29 C.F.R. § 2590.702(f)(3)(v); 45 C.F.R. §§ 146.121(f)(3)(v), 147.110(f)(3)(v). This provision is critically important to ensure that the right to a reasonable alternative standard or a waiver may be exercised in a meaningful way.

Accordingly, the final rule should require that the notice include not just a description of the availability of other means of qualifying, but also a full description of all necessary steps that an individual must take in order to seek a waiver or an alternative standard, including the person and address to which such a request must be directed and the information that the request must contain. Moreover, all written notices must be available in alternative formats such as Braille, large font print, audio-recordings, or electronic formats, and plan materials online must be posted on websites that meet accessibility standards, and include a reference to the availability of reasonable accommodations and policy modifications within the program.

Appeal rights: The final rule should require that wellness programs provide a process for individuals to appeal, and provide notice of the right to appeal, a decision not to provide a "reasonable alternative standard (or waiver of the applicable standard) for obtaining the reward." 26 C.F.R. §§ 54.9802-1(f)(3)(iii)(A)(1), (2); 29 C.F.R. §§ 2590.702(f)(3)(iii)(A)(1), (2); 45 C.F.R. §§ 146.121(f)(3)(iii)(A)(1), (2), 147.110(f)(3)(iii)(A)(1), (2). The final rule should also state the right of employees to complain about such adverse determinations to the Department of Labor Office For Civil Rights. Additionally, the final rule should require that such notice include each of the protections described herein, so that individuals participating in the program are aware of their rights.

Size of reward in smoking cessation programs: The proposed rule permits rewards and penalties of up to 50% of the cost of coverage where a health-contingent wellness program is designed to prevent or reduce tobacco use. We urge the agencies to use their discretion not to permit such dramatic penalties and rewards for individuals in these programs. This provision has the potential to have a devastating effect on individuals with psychiatric disabilities, who are about twice as likely as other persons to smoke, and who may encounter greater difficulty with tobacco cessation.[3] In light of the disparate impact that a penalty of 50% of the cost of coverage would have on individuals with psychiatric disabilities, we do not think that the agencies should "determine that such an increase is appropriate." 42 U.S.C. § 300gg-4(j)(3)(A).

[3] Karen Lasser *et al.*, *Smoking and Mental Illness: A Population-Based Prevalence Study*, 284 J. Amer. Med. Ass'n. 2606 (2000), available at http://jama.jamanetwork.com/article.aspx?articleid=193305#qundefined.

2. The Americans with Disabilities Act (ADA) Applies Concurrently to Wellness Programs.

Applicability of the ADA: The ADA prohibits workplace discrimination against employees with disabilities with regard to, among other things, employment benefits such as workplace wellness programs. *See* 42 U.S.C. § 12112(a)-(b).[4] The ADA's applicability was recognized by Rand Health's wellness programs review sponsored by the Departments of Labor and Health and Human Services in anticipation of the release of the proposed rule: "The Affordable Care Act does not, however, supersede other federal requirements relating to the provision of incentives by group health plans, including requirements of the Genetic Information and Nondiscrimination Act (GINA) and the Americans with Disabilities Act (ADA)."[5]

The ADA has for more than twenty years prohibited discrimination against and governed reasonable accommodation of people with disabilities in the workplace – including in workplace wellness programs – and thus must be read *in pari materia* with the ACA. Congress chose to enact the Affordable Care Act's provisions concerning wellness programs without stating that these provisions applied "notwithstanding any other provision of law." Indeed, Congress considered *and rejected* amendments concerning wellness programs that would have provided, for example, that:

> Nothing in the Americans with Disabilities Act of 1990, title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, or the Genetic Information Non-discrimination Act of 2008 shall be construed to prohibit a covered entity from adopting, sponsoring, administering, or providing products or services in connection with, or relating to, programs of health promotion or disease prevention that requests individuals to participate in medical examinations, answer medical inquiries, or complete

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[4] The ADA also prohibits public accommodations from discriminating on the basis of disability "in the full and equal enjoyment" of "goods, services, facilities, privileges, advantages, or accommodations." 42 U.S.C. § 12182(a); *see also* Carparts Distribution Ctr., 37 F.3d 12 (1st Cir. 1994) (concluding that Title III of the ADA is not limited to the provision of goods and services in physical structures, but also covers goods and services offered by a place of public accommodation through other means, such as telephone or mail). And the ADA provides that people with disabilities shall not "be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The ADA also requires "reasonable modification" of policies, practices, or procedures of places of public accommodation and public entities to allow individuals with disabilities to participate. *Id.* at §§ 12182(b)(2)(A)(ii), 12132; 28 C.F.R. § 35.130(b)(7). Language in the preamble makes clear that the proposed rule does not apply to public accommodations in the individual marketplace. *See* 77 Fed. Reg. 70621 (Nov. 26, 2012) ("…this proposed rule does not include wellness program policy for the individual market[].") However, the proposed rule is less clear as to its inapplicability to wellness programs created under the Medicaid program. *See* 42 U.S.C. § 300gg–4(j)(1)(A) (defining a wellness program under the ACA as one "offered *by an employer*") (emphasis added). We suggest that the final rule state that wellness programs offered pursuant to the Medicaid program are not governed by the ACA's wellness program provisions, and instead fall under 42 U.S.C. §§ 1315, 1396v and those sections' implementing regulations.

[5] Soeren Mattke *et al.*, Rand Health, "A Review of the U.S. Workplace Wellness Market," at 7, available at http://www.dol.gov/ebsa/pdf/workplacewellnessmarketreview2012.pdf.

health risk assessments or questionnaires, if such requirements are otherwise authorized under this Act.

Congress' decision to enact the ACA without such language demonstrates its intent that the ADA have parallel applicability to wellness programs. The ADA and the ACA therefore must be read together and regulations implementing the wellness programs provisions of the ACA should state unequivocally that the ADA is equally applicable.

Given this parallel applicability, we urge the implementing agencies to consult with and give deference to the Equal Employment Opportunity Commission and the Justice Department, the agencies charged with enforcing Titles I, II and III of the ADA, during the process of developing final regulations. The EEOC has been interpreting the ADA, including as it pertains to workplace wellness programs, for more than twenty years, and can bring significant expertise to bear on these issues.

a) **The ADA requires reasonable accommodation of employees with disabilities in wellness programs.** The ADA requires employers to reasonably accommodate disabled employees to ensure that they have rights and privileges in employment equal to those of nondisabled employees, including the right to participate equally in workplace activities like wellness programs. 42 U.S.C. § 12112(b)(5). The ADA's reasonable accommodation provisions apply with equal force to participatory wellness programs and health-contingent wellness programs.

   Regarding participatory wellness programs, the proposed rule essentially posits that such programs are *de facto* non-discriminatory if they do not provide rewards for satisfying a standard related to a health factor, but instead provide rewards merely for participation, and if participation is made available to all "similarly situated individuals." 26 C.F.R. § 54.9802-1(f)(1); 29 C.F.R. § 2590.702(f)(1); 45 C.F.R. §§ 146.121(f)(1), 147.110(f)(1).

   This portion of the proposed rule overlooks the fact that many people with disabilities are *not* "similarly situated" in terms of capacity to participate in such programs, regardless of whether rewards or penalties are attendant upon the outcome, and cannot partake in inaccessible activities that a program seeks to incentivize through reimbursement. For example, a wellness program offering reimbursement for membership at a fitness center that does not offer physical accessibility, universally designed fitness equipment, and/or reasonable modifications of policies and procedures, such as excusing a personal attendant from paying for admission, fails to provide equal opportunity to many individuals with disabilities.

   We therefore urge the implementing agencies not to deem all participatory wellness programs that have a reward or penalty attached to participation as "non-discriminatory." Instead, participatory wellness programs must meet the same non-discrimination

requirements as health-contingent wellness programs whenever participation is incentivized through the imposition of an award or a penalty.

Regarding health-contingent wellness programs, the proposed rule protects employees by requiring provision of a "reasonable alternative standard (or waiver of the applicable standard) for obtaining the reward" as part of a health-contingent wellness program for an employee "for whom, for that period, it is unreasonably difficult due to a medical condition" or "medically inadvisable" to "attempt to satisfy the otherwise applicable standard." 26 C.F.R. § 54.9802-1, 29 C.F.R. § 2590.702, and 45 C.F.R. §§ 146.121 and 147.110 at ¶ (f)(3)(iii)(A)(1) and (2); *see also id.* at ¶ (f)(3)(iv) ("… the plan must make available to any individual who does not meet the standard based on the measurement, test, or screening a different, reasonable means of qualifying for the reward.") Employees must affirmatively request a "reasonable alternative standard," and may be asked to provide verification of the employee's claim that it would be "unreasonably difficult" or "medically inadvisable" to attempt to satisfy the standard. 26 C.F.R. § 54.9802-1, 29 C.F.R. § 2590.702, and 45 C.F.R. §§ 146.121 and 147.110 at ¶ (f)(3)(iii)(B) and (C). A "medical professional who is an employee or agent of the plan" may be involved in determining a reasonable alternative standard. 26 C.F.R. § 54.9802-1, 29 C.F.R. § 2590.702, and 45 C.F.R. §§ 146.121 and 147.110 at ¶ (3)(iii)(B)(3).

We urge the implementing agencies to require that employees who request a "reasonable alternative standard (or waiver of the applicable standard) for obtaining the reward" be treated as if they were requesting a "reasonable accommodation" under the ADA. The proposed rule does not define the terms "unreasonably difficult" or "medically inadvisable," or explain clearly how the "verification" process – including the involvement of a medical professional who is an employee or agent of the plan – will function. In contrast, the ADA's reasonable accommodation standard and process – including the gathering of supporting documentation and the involvement of medical professionals – has been well-used and well-defined over more than twenty years and is familiar to employers.

And it is equally critical that the requisite "reasonable design" of health-contingent wellness programs be free of discrimination, so that all employees have an equally effective chance of realizing the benefits of the program. We recommend that the final rule incorporate the principle that a wellness program is not "reasonably designed" if it fails to ensure reasonable accommodations within the program for employees with disabilities who wish to participate. For example, wellness programs must ensure effective communication by providing print materials in alternative formats, Sign Language interpreters when required by Deaf and hard-of-hearing individuals, and websites and applications for other electronic devices that meet current accessibility standards. If a program requires use of equipment such as exercise equipment, accessible equipment must be available. Extended appointment times and

smaller or private counseling sessions must also be offered for individuals who require additional time for communication or mental processing, or who have difficulty functioning in larger group settings.

b) The ADA limits disability-related inquiries by participatory and health-contingent wellness programs. The ADA limits disability-related inquiries during employment so as to prevent discrimination and protect employee choice about whether and how to disclose a disability. 42 U.S.C. § 12112(d). The ADA excepts workplace wellness programs from these limitations to the extent such programs include "voluntary medical examinations, including voluntary medical histories." *Id.* at § 12112(d)(4)(B). Medical exams or inquiries conducted as part of workplace wellness programs are not "voluntary" under the ADA where they are mandatory or include penalties for failing to complete such exams or inquiries.[6]

The final rule should state that neither participatory nor health-contingent wellness programs may force employees to participate in medical exams, health risk assessments or other medical inquiries, or penalize employees who choose not to participate (including by offering rewards to employees who do choose to participate). *See, e.g.,* 26 C.F.R. §§ 54.9802-1(f)(1)(ii), (iv), (vi), and (f)(2)(i), (ii); 29 C.F.R. §§ 2590.702(f)(1)(ii), (iv), (vi), and (f)(2)(i), (ii); 45 C.F.R. §§ 146.121(f)(1)(ii), (iv), (vi), and (f)(2)(i), (ii), 147.110(f)(1)(ii), (iv), (vi), and (f)(2)(i), (ii) (providing examples of programs that could include rewards or penalties tied to completion of medical exams, health risk assessments, diagnostic testing, or other medical inquiries). Such a revision would apply the ADA *in pari materia* with the ACA, which does not authorize penalties for failure to participate in medical exams, health risk assessments or other medical inquiries.

The final rule should also make clear that an employer or wellness program may not retaliate against an employee who refuses to participate in a medical exam, health risk assessment or other inquiry that is not required by law.

c) The ADA requires that medical information be kept confidential: The final rules should also state that information obtained as a result of a workplace wellness program's voluntary medical exam, health risk assessment or other inquiry – whether in a participatory or health-contingent wellness program – must be "collected and maintained on separate forms and in separate medical files and [] treated as a confidential medical record" in accordance with the ADA. 42 U.S.C. § 12112(d)(3)(B), (d)(4)(C).

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[6] *See* EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the ADA at ¶ 22 (July 27, 2000) (available at www.eeoc.gov/policy/docs/guidance-inquiries.html).

In sum, the undersigned organizations urge the Departments of Labor, Health and Human Services and Treasury to incorporate the ADA's important protections and standards into the final rule implementing these provisions of the ACA. Congress did not intend the ACA to abrogate the ADA; in fact Congress only recently amended the ADA to strengthen its prohibition of discrimination and protection of people with disabilities. *See* ADA Amendments Act of 2008, Public Law 110-325, 42 U.S.C. § 12101, *et seq.* (September 25, 2008). These important prohibitions and protections are essential to increasing employment of people with disabilities and protecting them from discrimination and unwarranted intrusion into their health status during employment.

We appreciate the opportunity to comment on the proposed rule. As implementation moves forward, we hope to have the opportunity to work with the Departments of Labor, Health and Human Services, Treasury and other agencies charged with enforcing this important law.

Sincerely,

American Association on Health and Disability

American Network of Community Options and Resources

American Speech-Language-Hearing Association

American Therapeutic Recreation Association

The Arc of the United States

Association of University Centers on Disabilities

Bazelon Center for Mental Health Law

Brain Injury Association of America

Center for Disability Issues & Health Policy

Council of State Administrators of Vocational Rehabilitation

Disability Rights Education and Defense Fund

Disability Rights Legal Center

Easter Seals

Epilepsy Foundation

Institute for Educational Leadership

Mental Health America

National Alliance on Mental Illness

National Disability Rights Network

National Down Syndrome Congress

National Down Syndrome Society

National Multiple Sclerosis Society

Paralyzed Veterans of America

United Spinal Association