June 19, 2015

Via Federal eRulemaking Portal

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

Re: RIN number 3046-AB01; Notice of Proposed Rulemaking Regarding Title I of the American with Disabilities Act (“ADA”) As It Relates to Employer Wellness Programs

Dear Ms. Wilson:

The Society for Human Resource Management (“SHRM”), is pleased to provide its comments in response to Notice of Proposed Rulemaking (the “Proposed Rule”) which the U.S. Equal Employment Opportunity Commission (“EEOC” or “Commission”) published in the Federal Register on April 20, 2015. The Proposed Rule would amend the regulations under Title I of the American with Disabilities Act (“ADA”) to provide guidance on the extent to which employers may offer incentives to encourage employees to participate in wellness programs that include disability-related inquiries or medical exams.

I. BACKGROUND ON SHRM

Founded in 1948, SHRM is the world’s largest HR membership organization devoted to human resource management. Representing more than 275,000 members in over 160 countries, the Society is the leading provider of resources to serve the needs of HR professionals and advance the professional practice of human resource management. SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China, India and United Arab Emirates.

SHRM has long supported workplace wellness programs. We believe that wellness programs can improve health and enhance productivity of employees. SHRM was a strong supporter of
including provisions in the Affordable Care Act ("ACA") aimed at promoting widespread adoption of wellness programs. We support policies that will enable employers to continue to offer these programs to their employees. SHRM believes, as demonstrated by research, that a healthy workforce is more productive, with reduced absenteeism and greater employee enjoyment. Studies show that the costs for medical and other benefits such as short- and long-term disability costs often decrease significantly with increased wellness participation. Employers have experienced decreased incidents of workers’ compensation and their related costs when wellness programs are linked with workplace safety programs as well.

II. COMMENTS

SHRM appreciates that the Commission has embarked on the challenging task to “interpret the ADA in a manner that reflects both the ADA’s goal of limiting employer access to medical information and the Health Insurance Portability and Accountability Act ("HIPAA")’s and ACA’s provisions of promoting wellness programs.”

Although the Commission has stated that it is looking to provide as much consistency as possible between the ADA and HIPAA,

there are a number of significant differences between the Proposed Rule and HIPAA. There are also marked differences between a number of provisions in the Proposed Rule and the language Congress included in the ACA which would substantially impact employers’ flexibility in designing wellness programs and offering these programs.

SHRM would like the Commission to know that we share its goal that all employers offer workplace wellness programs which will promote health, deter disease, and foster healthy lifestyle habits in a non-discriminatory manner.

We appreciate that the Commission has the statutory authority under Title I of the ADA to limit incentives for participation in employer wellness programs if such incentives will render an employee’s provision of medical information “involuntary.” However, there are provisions within the Proposed Rule and Interpretative Guidance which we believe fall outside the scope of the Commission’s statutory authority and beyond its area of expertise. We are also troubled by a number of requirements in the Proposed Rule which we believe are impractical, burdensome and counter-productive to the goals of the ACA. It is our view that these provisions must be changed so that the final ADA regulation does not serve as a major disincentive, curbing employers’ ability to develop and offer effective workplace wellness programs to assist employees in helping improve their health.

Incentive-based wellness programs are still a relatively new phenomenon for many organizations. Congress and the Department of Labor, the Department of Health and Human Services, and the Department of Treasury ("the Departments") have all recognized that employers will need time to implement wellness programs, gauge the impact on their workforce and innovate these programs,

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2 EEOC, Questions and Answers about EEOC's Notice of Proposed Rulemaking on Employer Wellness Programs, available at http://www.eeoc.gov/laws/regulations/qanda_nprm_wellness.cfm (last visited June 18, 2015) (“EEOC's goal in the NPRM was to provide as much consistency as possible between the ADA and HIPAA.”).
3 80 Fed Reg. 21659, 21662
as needed. The ACA and joint regulations issued by the Departments on June 3, 2013, ("Tri-Care Agency regulations") have provided employers with the autonomy they need to find the types of wellness programs and incentives that will drive healthy habits in their own workforce. It is imperative that the Commission also recognizes these important principles in its final regulations.

SHRM believes that any differences between the final ADA regulations and the ACA and Tri-Care Agency regulations must be warranted and necessary for the purpose of preventing discrimination against individuals with disabilities and effectuating the purposes of Title I of the ADA. One difference that SHRM agrees is necessary and warranted, is the inclusion of participatory wellness programs that include medical exams or inquires in the Proposed Rule. Even though incentive based participatory wellness programs are exempt from comparable requirements under the ACA and Tri-Care Agency regulations, we are comfortable with including these wellness programs in the ADA regulations. SHRM urges the Commission to issue regulations that will enable employers to continue to incentivize employee participation in wellness plans under the ADA.

1. The Proposed Rule Would Disregard Use of Incentives in Plus One & Family Plans

Under the Proposed Rule, an incentive that exceeds 30 percent of the total cost of “employee-only coverage” would render the employer’s wellness program “involuntary” under the ADA. Yet there is no such limitation under the ACA and the Tri-Care Agency regulations. In fact, the ACA expressly permits employers to offer incentives based upon the cost of the wellness program the employee selects. It provides, “[i]f, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program; such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled.”

HIPAA, as amended by the ACA, also expressly permits the maximum incentive to be calculated based on the costs of the program the employee selects. Based upon HIPAA as well as the ACA, many employers have either already expanded or plan to expand earlier wellness efforts to incentivize spouses, and in some cases even children, towards wellness goals by utilizing the allowable up-to-30-percent incentive on family coverage. In fact, 50 percent of respondents to SHRM’s survey on workplace wellness programs offered wellness initiatives to spouses and other dependents last year. That represents a five percent increase over the prior year.

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For example, one employer went so far as to build a new wellness incentive program specifically encouraging spouses of employees to complete a questionnaire and then receive one-on-one counseling if three or more health risks were identified. If the spouse then saw his/her primary care physician for further evaluation or treatment, the employee received a discount on their premium co-share of 25 percent of the family coverage amount, a significant (and allowable) incentive. A large hospital group similarly adopted an employee-plus-spouse wellness program with increased premium co-share savings based upon the cost of employee-plus-spouse coverage where both the employee and spouse completed a health risk appraisal with biometric screening. Another SHRM member reported that offering a monetary incentive to employees and their spouses has driven participation in their wellness program to 65 percent, and expressed concern that the Proposed Rule will force their organization to restructure their plan design, having a significant impact on participation.

There are a number of reasons why employers include spouses in their wellness programs. Health researchers have found that spouses are a key influence on an individual’s behavior and long-term success. Two studies from Christakis and Fowler published in the New England Journal of Medicine in 2007 and 2008 revealed that when a spouse is obese, the likelihood of the other spouse becoming obese increased by 37 percent, and further that when a spouse stopped smoking, it decreased a person’s chances of smoking by 67 percent. An analysis conducted by the Health Enhancement Research Organization (“HERO”)’s Research Committee found that employers who include spouses in key components of their health management programs reported higher employee participation. In addition, many employers include employees’ spouses in their wellness programs in an effort to curb costs. This appears to be a solid business strategy as studies show that the average spouse typically costs 30 percent higher than the average employee to insure.

Congress no doubt considered these reasons and others when they included the costs of dependent coverage in the incentive cap allowable under the ACA. Given the policy reasons supporting the inclusion of family members and the prevalence of these programs, it is difficult to understand why the proposed rule contains this limitation. SHRM notes that the Commission issued “Questions and Answers about EEOC’s Notice of Proposed Rulemaking on Employer Wellness Programs,” which included the question, “Why does the NPRM set the incentive to 30 percent the cost of ‘self only’ coverage?” In answering the question, the Commission emphasized that the “goal in the NPRM was to provide as much consistency as possible between the ADA and


9 Id.

10 HERO is a non-profit corporation dedicated to the creation and dissemination of employee health management research, education, policy, strategy, and leadership. Among other things, HERO’s analysis of 2012 data showed that the average employee participation rate for tobacco cessation programs was 2% higher in companies that included spouses in employee health management programs as compared to companies that did not include the spouse in its program.

HIPAA,” yet it did not explain why employees who select plus-one or family plans may be subjected to a different standard under the ADA. If the final ADA regulation is not revised to make clear that financial incentives are limited to 30 percent the cost of the plan in which the employee is enrolled, it will impede a growing segment of our population who is insured through a family member from benefitting from an employer sponsored wellness program. SHRM therefore recommends that the Commission base the incentive limit on the plan the employee selects, in accordance with the standards set forth in the ACA and the Tri-Care Agency regulations.

2. The Proposed Rule Should Not Preclude Employers From Offering Enhanced Incentives For Programs Aimed At Curbing Tobacco Use

In the ACA, Congress authorized the Secretaries of the Departments of Labor, Health and Human Services, and Treasury to increase the maximum reward employers are allowed to offer employees for participation in a wellness program to as much as “50 percent the cost of coverage if the Secretaries determine that such an increase is appropriate.” In accordance with that authority, in the 2013 Tri-Care Agency regulations, the Departments expanded the incentive limit “by an additional 20 percentage points (to 50 percent) to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.”

Many employers have long recognized the link between smoking and health care incidents and costs, and they have moved to adopt smoking cessation programs with significant incentives (and success) for employees. These programs frequently rely upon biometric screenings, which test a byproduct of nicotine, to verify whether employees are using tobacco. Following the issuance of the 2013 Tri-Care Agency regulations, which increased the allowable incentive for health contingent wellness programs aimed at smoking cessation, many employers began designing programs to accelerate those plans. A number of HR Professionals reported that their organizations now include incentives up to and including 50 percent for wellness programs that test for nicotine usage. For example, a manufacturer of 300 employees adopted an aggressive program with biometric testing for nicotine and was able to reduce the number of employees who smoke by over 78 percent. Yet under the Proposed Rule, no greater incentive for such an evidence-based program would be available. An employer who already offered a wellness incentive of 30 percent of employee-only premium cost would not be permitted to layer on a smoking cessation effort with an additional incentive.

SHRM agrees with the Commission’s view that an employer wellness program that merely asks employees whether they use tobacco, would not be subject to the ADA, because a question about tobacco use does not qualify as a disability-related inquiry since tobacco use is not a disability. However, we disagree with the Proposed Rule to the extent that it would impose a flat 30 percent limitation on incentives for any wellness program which tests for nicotine usage through a

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biometric screening or other medical exam. SHRM urges the Commission to adopt a rule that is consistent with the ACA and the 2013 Tri-Care Agency regulations so that employers can continue to offer enhanced incentives to foster employee participation in evidenced-based tobacco cessation programs.

3. The Inclusion of a Flat Percent Incentive Cap Infringes Upon the Departments’ Discretion

Beyond tobacco cessation, the inclusion of a flat 30 percent limitation in the Proposed Rule raises additional concerns. As noted previously, the ACA expressly authorizes an increase in the maximum award up to an additional 20 percent, if and when the Departments “determined that such an increase is appropriate.” Given that Congress entrusted the Departments with the express authority and latitude to increase the incentives associated with employer-sponsored wellness programs as they deem appropriate, we are concerned that the inclusion of a numerical limitation in the ADA regulations could inhibit and ultimately infringe upon the discretion Congress bestowed upon the Departments. Instead of expressly limiting the maximum award for participation in wellness programs to “30 percent of the total cost of employee coverage,” SHRM recommends that the final regulations link the percentage of what would constitute an acceptable incentive under the ADA to the incentive limits set by the Secretaries of Treasury, Labor, and Health and Human Services under the relevant sections of the Tri-Care Agency regulations.

4. The Proposed Rule Would Preclude Employers From Offering Gateway Plans Even Though They Are Permissible Under Current Law

SHRM is also concerned that the Proposed Rule will limit employers’ flexibility in designing health benefits packages for those employees who choose to participate in wellness programs. Under HIPAA, as amended by the ACA, and as reflected in the Tri-Care Agency regulations, employers are permitted to offer a variety of benefit options under a health plan, including offering certain options to employees who are willing to participate in wellness programs. For example, it is not uncommon for an employer to offer a traditional preferred provider organization (“PPO”) and a high deductible health plan (“HDHP”) to wellness participants even if the employer only offers a HDHP to the employees who do not participate in its wellness program. So long as an employer offers all similarly situated employees the opportunity to participate in it health plans, and every employee, including those who do not want to participate in wellness program, continue to have access to affordable comprehensive health care coverage, as required under the ACA, these “gateway” plans are permissible under current law.

We are aware of a number of employers who have successfully adopted gateway plan designs in which certain plan options that are only available to employees if they agree to participate in a non-biometric health risk assessment. For example, one employer of over 1,000 employees adopted such a program in order to encourage employees to enroll in a qualified high-deductible health plan with an employer Health Savings Account (“HSA”) contribution. In order to enroll in this plan, employees were required to complete a health risk appraisal (with no biometric data required or collected). Since implementing this approach, that employer has seen an increase of
over 40 percent enrollment in the richer HSA program and a corresponding reduction in absenteeism and health plan costs in their largest diagnostic area, diabetes.

Even though these gateway programs are a common plan design and permissible under current law, they would be prohibited under the Proposed Rule. Given the increasing popularity of these gateway programs and the fact that employers who have implemented these plans have seen a reduction in absenteeism and a decrease in employer and employees’ health care costs, a new regulation that suddenly deems these programs involuntary will prove to be incredibly disruptive for employer-sponsored healthcare plans. We also anticipate that the inclusion of this provision will constrain creativity and prevent employers from developing innovative and effective wellness programs in the future. Accordingly, SHRM respectfully urges the Commission to either eliminate this provision or to include a “carve out” provision in its final rule that would permit employers to continue to offer gateway plans to employees who participate in wellness programs.

5. The “Reasonably Designed” Requirement Exceeds EEOC’s Statutory Authority Under the ADA

The Proposed Rule also includes the requirement that, “an employee health program, including any disability-related inquiries and medical examinations that are part of such program, must be reasonably designed to promote health or prevent disease.” The Interpretative Guidance includes specific examples of wellness programs that would not satisfy the ADA’s reasonably designed requirement. For example, a wellness program that “requires an overly burdensome amount of time for participation requires unreasonably intrusive procedures or places significant costs related to medical examinations on employees” as a condition to obtaining a reward would not be considered reasonably designed to promote health or prevent disease under the Proposed Rule.

The requirement that a workplace wellness plan must be “reasonably designed” is not new. The Departments originally promulgated this requirement in the 2006 HIPAA regulations, which were then largely codified by the ACA. A health-contingent wellness program will comply with the ACA’s “reasonably designed standard if “it has a reasonable chance of improving the health of, or preventing diseases in, participating individuals.” It is worth noting that the Departments largely resisted those commenters who urged them to adopt more stringent standards for a wellness plan to be considered “reasonably designed.” Rather than implementing a rigid set of pre-approved wellness program structures or requiring that employers adhere to strict guidelines

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13 80 Fed. Reg. 21667 (proposed Apr. 20, 2015). Proposed Rule Section 1630.14(d)(2)(ii) provides that for a wellness program which includes disability-related inquiries and medical examinations to be considered voluntary, a covered entity may not deny coverage under “any of its group health plan or particular benefits packages within a group health plan.” Id.
14 Id.
16 42 U.S.C. §300gg-4(j)(3)(B). The full definition also includes that “it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health and disease. Id. It is worth noting that the Proposed Rule differs in that from the definition in ACA by substituting “violating the ADA or other laws prohibiting employment discrimination” for “based on a health status factor.” 80 Fed. Reg. 21667 (proposed Apr. 20, 2015).
in the Tri-Care Agency regulations, the Departments opted instead to “continue to provide plans and issuers flexibility and encourage innovation.”

While the Departments have been given the express statutory authority to regulate health care, including determining whether an employer-sponsored wellness program is “reasonably designed to promote health and prevent disease,” the Commission’s statutory authority is far more circumscribed. Indeed, apart from individual accommodation issues, the Commission’s authority to regulate workplace wellness programs under Title I of the ADA is limited to the determination of what constitutes a “voluntary” medical examination or inquiry.

Specifically the ADA provides:

A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to the employees at that work site.

Since the ADA does not define “voluntary,” the Commission must determine whether certain incentives that an employer offers its employees for participating in a wellness program, which includes a medical examination or inquiry, would render the medical and examinations or inquiry “involuntary.” The Commission does not have the authority to render an opinion as to whether the wellness program itself is “voluntary.” SHRM believes that if the Proposed Rule were adopted as currently written, the Commission will be examining all aspects of the wellness program, and in particular, aspects of plan design that go well beyond its limited statutory authority.

The EEOC serves a critical function as this nation’s premier civil rights agency, charged with enforcing our workplace anti-discrimination laws. It has neither the health care expertise nor the resources to evaluate the efficacy of employer health plans. This is the province of the Departments. There is no need for the Commission to decide whether a wellness plan is reasonably designed to promote health or prevent disease. We respectfully urge the Commission to limit its regulations to those discrete issues within the agency’s statutory authority. We recommend that the Commission acknowledge the Tri-Care Agency regulations and defer to the Departments’ expertise as the authority to determine if a wellness plan is designed to promote health or prevent disease.

6. The Commission Should Not Opine on the ADA Safe Harbor

We note that the application of the ADA “bona fide benefit plan” safe harbor has not been addressed in the text of the Proposed Rule. Instead, the Commission has included a footnote in the Preamble stating that it does not believe that “the ADA’s ‘safe harbor’ provision applicable to insurance as interpreted by the court in Seff v. Broward County, 691 F.3d 1221(11th Cir.

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2012)...is the proper basis for finding wellness program incentives permissible.”\(^{19}\) We respectfully disagree with this approach.\(^{20}\) Given that the bona fide benefit plan safe harbor has been codified in the ADA, and its application to wellness program has been affirmed by the Eleventh Circuit, absent a corresponding change in the statute providing the Commission authority to do so, we do not believe that the Commission may use these any part of these regulations to try to unilaterally write the exemption’s application out of the ADA.

In fact, we do not believe that the Commission currently has the authority to issue any regulations interpreting the ADA’s safe harbor. While the Commission has the authority to interpret Title I of the ADA, the safe harbor provision is contained in Title V of the statute.\(^{21}\) Therefore SHRM does not believe the Commission has the authority to interpret or comment on the ADA’s safe harbor in this rulemaking. SHRM urges the Commission to remove the footnote and any reference to the ADA safe harbor from its final rule.

7. **The Proposed Rule Will Discourage the Use of Non-Financial Incentives**

Employers often offer additional non-financial incentives in an effort to spur employee interest and participation in wellness programs. Non-financial incentives can range from small trinkets to prizes, gift-cards to in-kind encouragements, such as days-off work. While non-financial inducements are not tracked under the ACA and Tri-Care Agency regulations, the value of non-financial incentives provided to wellness plan participants would count towards the incentive cap under the Proposed Rule.

Our members tell us that the responsibility of tracking and valuing non-financial incentives will increase the administrative burdens associated with wellness programs. Faced with this increased burden, many employers will decide that they can no longer hand out t-shirts and gift cards, will cease offering paid-time off to wellness participants, and are more likely to eliminate other small tokens rather than dealing with the complexity of quantifying and tracking these items. SHRM believes that including this new requirement in the ADA regulations is unnecessary and imprudent as non-monetary inducements can make a difference, motivating certain individuals to participate in programs that could ultimately improve their health.

8. **The Final Regulation Should Not Include an Affordability Component**

The Commission has requested public input on whether it should import the ACA’s affordability standard into the final ADA regulations. Specifically in Question 1(b) of the Proposed Rule, the

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\(^{19}\) 80 Fed.Reg. 21662 (proposed Apr. 20, 2015). The ADA’s safe harbor provision can be found at 42 U.S.C. § 12201(c).

\(^{20}\) SHRM is in not asserting that all wellness plans will fall within the ADA safe harbor, but rather that it is possible, based on the structure of the underwriting, classifying and administering the risks, for a wellness plan to fall within the ADA safe harbor.

\(^{21}\) See 42 U.S.C. § 12116 (“[T]he Commission shall issue regulations in an accessible format to carry out this subchapter in accordance with subchapter II of chapter 5 of Title 5 [the Administrative Procedure Act]”); 42 U.S.C. § 12205a (granting the EEOC authority to issue regulations implementing the changes to the definition of disability under the ADA Amendments Act of 2008).
agency queries whether it would be appropriate for the Commission to provide that if the incentive employers offer to employees to promote participation in wellness programs renders health insurance unaffordable for an individual under the ACA, “it would be deemed coercive and involuntary to require an individual to answer disability-related inquiries or to submit to medical examinations in connection with a wellness program at issue.”

The ACA’s affordability standard is intended to ensure that employers offer at least one “affordable” health insurance plan to their eligible employees. An employer will comply with the ACA’s affordability standard by simply offering a health insurance plan that meets that law’s content and affordability parameters. This holds true regardless of whether the employee enrolls in the “affordable” plan or instead, decides to enroll in a different, more costly health plan option that does not meet the standard. The ACA’s “affordability” standard cannot be used as a basis for concluding that the incentive for participation in a wellness program in the health plan an employee actually selects renders the employee’s participation “involuntary” under the ADA. Indeed, a true analysis of “affordability” of an incentive under the ADA is unrealistic and unworkable, particularly as the EEOC ignores the ACA statutory design of examining affordability under the least expensive plan offered by the employer. It would require an individualized inquiry of the affordability for each employee. An employer would need to analyze the cost of the health insurance plan each employee selected, the amount of the financial incentives offered, and the employee’s household income. And, we would note that this analysis is not practical in the absence of complementary Genetic Information Nondiscrimination Act of 2008 (“GINA”) regulations which will undoubtedly discuss spousal or dependent coverage. Given that the affordability component exists under a completely separate statutory framework and is already regulated under extensive and complex regulations by agencies with expertise in the area of health care benefits, it would be a mistake for the Commission to attempt to try to import, or otherwise incorporate, the ACA’s “affordability” concept in its ADA regulations.

9. There is No Need to Add a New Requirement for Prior, Written, and Knowing Confirmation

The Commission has also requested comments on whether the notice requirements in section 1630.14(d)(2)(iv) of the Proposed Rule should include an additional requirement that employees provide prior written and knowing confirmation that their participation in a wellness program, which includes disability inquiries or medical examinations, is voluntary. The ADA does not include such a requirement and we do not believe that the inclusion of an additional written authorization is either warranted or necessary. In fact, instead of clarifying the issue, our members predict that such a requirement is likely to cause their employees to be confused and

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23 To be considered “affordable” the employee’s contribution may not exceed 9.5 percent of the taxpayer’s income. 26 U.S.C. §36(B)(c)(2)(C)(i). The regulations recognize that most employers do not have access to their employees’ household income. An employer can comply with the ACA’s affordability requirement by offering coverage that meets one of three “affordability” safe harbors. 26 C.F.R. § 54.4980H-5(e)(2).
frustrated. In addition, requiring employers to obtain written authorization from their employees will greatly increase the administrative burden and compliance costs. Accordingly, SHRM recommends that the Commission refrain from including a new written authorization requirement in its final rule.

10. GINA

Although Congress codified the 2007 HIPAA regulations in 2010, and the Departments subsequently issued the Tri-Care Agency regulations clarifying the rules surrounding wellness plan incentives, the uncertainty of the Commission’s position regarding the use of incentives in wellness plans under the ADA and GINA has hampered employers’ ability to plan for and offer wellness programs to their employees. The EEOC’s 2014 lawsuit against Honeywell International, Inc.25 only served to exacerbate employer concerns. At this juncture, employers simply want to understand the Commission’s position on the use of incentives. Many employers have moved forward with their wellness programs, but they have done so under the assumption that, after years of standing at the sidelines, the Commission would interpret the requirements of the ADA, HIPAA, and GINA simultaneously, and in as consistent a manner as possible. We were disappointed that the Commission decided to handle these interrelated issues in separate rulemakings. We would encourage the EEOC to consider issuing a revised proposal of this rulemaking along with its proposed GINA regulations.

Of the remaining issues under GINA, our members are most concerned about how the Commission will deal with the issue of spousal incentives in its GINA regulations. SHRM agrees that the wellness regulations should include appropriate safeguards to protect the disclosure of employees’ genetic information, but we are equally certain that GINA’s protections of “genetic information” was not intended to extend to current medical information about an employee’s spouse. Our members feel strongly that GINA be interpreted in a way that will not preclude employers from offering, or continuing to offer, covered spouses the incentives to encourage their participation in a wellness program that include medical examinations or inquiries.

III. CONCLUSION

As SHRM’s survey results illustrate, incentive-based wellness programs have become an important part of many organization’s health care cost containment strategies. Wellness initiatives are also an integral part of the benefits package employers offer to recruit and retain employees. Our members have found that offering financial incentives and other non-monetary rewards increases participation in wellness programs, leading to greater health benefits for employees and their families and reduced health care costs. SHRM encourages the Commission to issue regulations that will enable employers to continue to incentivize employee participation in wellness plans under the ADA. For all of these reasons, SHRM recommends that the Proposed Rule be revised to be more consistent with HIPAA, as amended by the ACA and implemented through the Tri-Care Agency regulations.

SHRM appreciates the opportunity to submit these comments and would be pleased to provide the Commission with additional information or clarification. We look forward to continuing to partner with the Commission to effectuate the promulgation of regulations that will be reasonable, enforceable and effective in fostering the real-world successes that employers and their employees have gained as a result of workplace wellness programs.

Respectfully Submitted,

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