

Employer Mandated Wellness Initiatives:

Respecting Workplace Rights While Controlling Health Care Costs

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Garry G. Mathiason
AnnaMary E. Gannon
Denise R. Abbott
Michael E. Brewer
Ellen M Bronchetti
Lisa C. Chagala
Russell D. Chapman
Michael G. Congiu
Marilyn E. Culp

Katherine Dix
Barry Y. Freeman
Steven J. Friedman
Philip L. Gordon
Gregory C. Keating
Suellen Oswald
Mark T. Phillis
Kelli A. Webb
Gregory J. Wiley

LITTLER MENDELSON, P.C.
THE NATIONAL EMPLOYMENT & LABOR LAW FIRM®

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Employer Mandated Wellness Initiatives — Respecting Workplace Rights While Controlling Health Care Costs

Introduction

Joe Pellegrini may have had a suspicion that someday he would become well-known as part of the wellness movement. He cycles 36 miles a day to and from work and is solid muscle. But he never could have imagined why his story was used to introduce the topic of workplace wellness in *Business Week's* February 26, 2007 issue.¹ Mr. Pellegrini is a supply-chain executive working at Scotts Miracle-Gro's headquarters in Marysville, Ohio. The \$2.7 billion dollar employer gave employees the choice of taking screening tests and, if needed, getting a health coach, or losing a significant portion of the employer's contribution toward medical insurance. Mr. Pellegrini's high protein diet apparently merited him a bad cholesterol score and a health coach. After several calls, a persistent coach persuaded the athletic Mr. Pellegrini to undergo a series of diagnostic tests. The results were shocking. A 95 percent blockage in two arteries gave him less than a week to live. Within hours of the diagnosis, two life-saving stents were inserted. The fact that this almost certainly would not have happened without his employer's wellness program made Mr. Pellegrini a national celebrity.

Stories like Mr. Pellegrini's are being repeated in thousands of workplaces as the decade-old trend of employer support for wellness programs matures. But the real question posed by Michelle Conlin in her *Business Week* article is captured by its title, *Get Healthy — Or Else: How far can an employer go toward mandating wellness in the workplace?* With health care costs projected to double by 2016, reaching \$4.2 trillion and representing 20 percent of every dollar spent, no employer can afford to leave this question unanswered. Health care costs and employer contributions toward health care premiums have increased to the level that they often determine whether a profit is made or whether the employer can continue in business. Every Board of Directors and C-suite executive of public companies in America has seen the face of this monster. Every conceivable form of health insurance coverage, co-payments, and premium

contributions has been tried. Yet the monster continues to grow and new solutions are being sought.

Employers are experiencing the development of a "perfect storm" in the workplace. Three forces are combining, threatening balance sheets and, in many cases, raising the question of business survival. First, medical costs are accelerating and with the coming health needs of the baby boomers, the increases promise to continue for at least another decade. Second, employees have more health care needs than ever before with an obesity epidemic, tobacco-related illness and death, and sedentary life styles. Third, a great worker shortage lies just ahead, especially in skilled positions. This mandates that employers will need to offer competitive benefits as an essential component of keeping and attracting talent. The force of this perfect storm promises to be so severe that the "wellness" of the workforce will become one of the most important corporate assets.

We have at least a decade of experience with voluntary workplace wellness programs. While the reports from these programs have been generally positive, they have also introduced the question — At what point do the programs become so intrusive they impact employee rights? What protections are available for employee privacy? Are disabilities accommodated? Are certain protected categories of employees being treated differently under these plans? Voluntary workplace wellness plans suggest the potential for conflict with individual employee rights, but they also have started a serious debate about what happens as the elements of a wellness plan move from strictly voluntary to strongly encouraged, and finally to required. While it would be easy to legally approve voluntary plans and prohibit mandatory ones, the economic realities of the perfect storm make it certain that employers will have no choice but to move closer to making workplace wellness a requirement.

To some extent every corporate employment attorney and senior human resources professional has or will be called upon

¹ Michelle Conlin, *Get Healthy — Or Else*, BUS. WEEK, Feb. 26, 2007, available at http://www.businessweek.com/magazine/content/07_09/b4023001.htm.

to answer the question: “How far can we go toward mandating wellness in the workplace?” Littler’s role is not to identify or advocate for any particular position on the road toward required wellness, but rather to provide the best possible legal analysis of the obstacles and options. Accordingly, this paper explores the legal issues associated with wellness plans as they evolve and points toward the dramatic changes that are coming.

Presented below is a short summary of the crisis in health care costs and a sampling of today’s wellness programs. This is followed by a review of the legal issues raised by such plans, especially as they involve significant incentive and mandatory requirements. Recently a prominent corporate counsel responsible for overseeing the employment law compliance of a global enterprise with 20,000 United States employees described the legal issues involved in wellness plans as some of the most complex and challenging ever encountered in her long career. We agree with that assessment, especially since little case law exists and many of the test cases are still years away from appellate scrutiny. Employers will need to make tough decisions today and in the near future based on anticipated judicial and regulatory treatment in the future.

Following the legal analysis described above, two wellness programs are reviewed. The first deals with a conservative program featuring voluntary options and incentives that start to move the program on the continuum leading to more mandatory requirements. The second sample plan moves much closer to a full mandatory wellness initiative that eventually causes an employee to face the decision of participating in the plan or leaving the workplace. While some hard lines can be drawn prohibiting employer requirements that conflict with statutory protections and regulatory requirements, in many other situations alternatives can be envisioned. These alternatives are not guaranteed legal solutions; they carry litigation risk. However, at some point the costs of insurance and the benefits of a healthy workforce will outweigh the risk of litigation. Those organizations that take reasonable risks may be the ones to receive the greatest rewards. Again, each employer will need to make individual decisions based on its core values and its tolerance for risk.

Normally a law firm is reluctant to craft options that contain anything above nominal litigation risk. Attorneys are

notoriously risk adverse. Wellness is an area where corporate values may dictate taking greater risk. Having a healthy workforce is enormously beneficial. Productivity goes up. Turnover goes down. Workplace injuries decline. Disabilities decline. Work life expands. Morale improves and the attractiveness of the workplace keeps productive workers and appeals to applicants. Health care costs go down! Doing this while still prohibiting harassment of individuals based not just on protected categories such as disability, but also because of their individual differences, including weight, is legally challenging, but not impossible. To facilitate the decision of where on the continuum of wellness plans your organization should be, today’s legal borders will be explored, coupled with our best judgment of the legal landscape over the next few years. This insight into the future is essential since actions taken today will likely be judged based on the case law of tomorrow.

I. The Crisis in Health Care Coverage

One of the greatest challenges that American employers face is the ever-increasing cost of employee health care. Without substantial controls, health care costs will seriously threaten the competitiveness of U.S. employers in the global economy. The current health care crisis is a problem so large that employers cannot escape it, yet not so impossible that employers are completely helpless to address it.

A. Magnitude of the Crisis

The costs of health care in the United States are rising at the fastest rate in history. In the past seven years, employer-based health insurance premiums have risen 4 times faster than wages.² Medical spending has reached \$1.9 trillion annually, or 16 percent of the national gross domestic product and is projected to climb to \$4 trillion, or 20 percent of the GDP, by 2015.³ Total national health care expenditures rose 7.9 percent in 2004, more than three times the rate of inflation.⁴

Forty years ago American medical spending was estimated at 5 percent of national income; today it is calculated at some 16.5 percent and rising continually.⁵ By 2016 health care costs will double to 4.2 trillion dollars.

² The annual premium for an employer health plan covering a family of four averaged nearly \$11,500. The annual premium for single covered averaged over \$4,200. National Coalition on Health Care, *Facts on Health Care Costs*, available at <http://www.nchc.org/facts/cost.shtml>.

³ Alex Gerber, *The Health Care Crisis*, WASH. TIMES, Commentary, Mar. 18, 2007, available at <http://www.pnhp.org>.

⁴ *Facts* National Coalition on Health Care, *Facts on Health Care Costs*, available at <http://www.nchc.org/facts/cost.shtml>.

⁵ Hans Sennholz, *Why is Medical Care So Expensive*, Aug. 22, 2006, available at <http://www.mises.org> [website for the Ludwig von Mises Institute].

B. Development of the Crisis

To understand the current status of “traditional” health benefits provided by employers, one must first appreciate how and why employer health benefits came into being. Only a short 60 years ago, employer sponsored health benefits simply did not exist. As a result of federal government restrictions on salaries during World War II, employers sought avenues to retain and recruit talented employees by offering employer sponsored health insurance because the federal regulations on salary control did not prohibit such a perk. Shortly thereafter, the employer sponsored health care coverage boom received another stimulus when Congress made clear that employers could include expenses for medical insurance as a deductible compensation expense while the value of the coverage was not included in the employee’s taxable income.

Between 1950 and 2000, employer sponsored health insurance became a widespread practice in the United States. Early private health insurance premium rates were set using what were called “community ratings” where most groups paid the same average rate for their insurance. Most individuals paid similar premiums regardless of the condition of their health. Thus, the healthy groups bore some of the costs of the less healthy.

This system began to unravel as health care insurers became adept at segmenting health risks by avoiding risky applicants and redlining whole industries and occupations, such as hazardous work and businesses with higher than average claims. Against this backdrop, other forces began to affect the ability of businesses to afford health insurance for their employees. Health care costs began to outpace growth and corporate and personal incomes.

As of 2000, roughly 70 percent of all private employers offered health insurance to at least some of their employees. That situation has changed dramatically in only the last six years. Particularly for firms with less than 100 workers, a sharp decline has occurred. Among all firms in the United States, the percentage of those offering health benefits since 2000 has dropped from 70 to 61 percent. Why? The cost for employer sponsored health insurance has escalated rapidly. Premiums for family coverage alone have increased by 87 percent since 2000.⁶

C. Impact on Employers

Skyrocketing employer health care costs are not surprising considering that the majority of Americans continue to lead unhealthy lifestyles by smoking, drinking, and eating poorly. Employer profits and even the ability to stay in business are being impacted by health care costs. The data is sobering.

- Starbucks spends more on health care than it does on coffee beans.⁷
- Of the \$5.3 billion General Motors spent on health care costs in 2005, an estimated 25 percent could be traced back to unhealthy habits such as overeating, lack of exercise, cigarettes, and alcohol.⁸
- Average health care expenditures for people with diabetes run about \$13,243 per person, compared with \$2,650 per person for people without diabetes. Even after the differences in age, sex, race and ethnicity are taken into account, people with diabetes had medical expenditures that were 2.4 times higher than comparable people without diabetes.⁹
- Employer health care costs attributed to obesity alone are estimated at \$12 billion each year.
- In a General Motors plant with 2,800 employees, data projects that 1,484 workers will be at least 15 to 20 pounds overweight (the level at which health care costs increase), 592 will suffer high blood pressure, 591 will smoke, 560 will have high cholesterol, and 514 do not exercise.¹⁰
- The average worker, retiree, and family member whose medical bills are paid by General Motors gets 15 prescriptions per year — 50 percent more than the national average. The automaker pays \$1.9 billion for prescription medicine alone.¹¹

What have employers done to confront this rising tide? Strategies for curtailing costs have included the following:

- Narrowing eligibility so that health insurance is not provided to part-time or temporary employees.
- Narrowing eligibility so that health insurance in

⁶ The Kaiser Family Foundation, *Employer Health Benefits 2006 Annual Survey*, available at <http://www.kff.org/insurance/7527/index.cfm>.

⁷ Devon M. Herrick, *Why Employer-Based Health Insurance Is Unraveling*, Health Care News, Nov. 1, 2005, available at <http://cdhc.ncpa.org/commentaries/why-employer-based-health-insurance-is-unraveling>.

⁸ Ron French, *Losing the Battle of the Bulge: Unhealthy Lifestyles Weigh Heavily on Company's Health Care Costs*, DETROIT NEWS.COM, Oct. 22, 2006, available at <http://detnews.com/apps/pbcs.dll/article?AID=/20061025/LIFESTYLE03/101220011/1040>.

⁹ U.S. Dept. of Health and Human Services Report on the Impact of Poor Health on Business, Sept. 16, 2003.

¹⁰ *Losing the Battle of the Bulge*, supra note 8.

¹¹ Ron French, *GM's Bitter pill; Automaker Spends Billions on Drugs for Aging Workers, Retirees*, DETROIT NEWS.COM, Oct. 25, 2006, available at <http://www.detnews.com/apps/pbcs.dll/article?AID=/20060927/LIFESTYLE03/609270383>.

unavailable until an employee has worked a certain number of hours.

- Increasing premiums charged to employees either under individual and family plans.
- Increasing employee co-payment for certain procedures.
- Increasing employee co-payment for certain drugs.

Employers are also moving away from a traditional plan with a deductible in favor of more progressively designed consumer-driven health plans. With these plans, employees receive a health savings account similar to a 401k. The employee uses that account to cover his or her first dollar medical expenses every year. Unlike flexible spending accounts with a “use it or lose it” requirement, dollars not spent on health care remain in the account. The presumed benefit of these new plans is that employees will assume greater responsibility for their health care spending and accordingly devote more energy towards their health. Of course, there is the risk that employees will stockpile the funds in their health savings account and neglect their health.

Some states and cities now require employers to provide health insurance. Massachusetts led the way, requiring employers with 11 or more full-time equivalent employees to offer health insurance to their employees and make a “fair and reasonable” contribution to its costs. California Governor Arnold Schwarzenegger has proposed that employers with 10 or more employees who do not offer health coverage will contribute an amount equal to four percent of payroll toward the cost of employee health insurance. San Francisco employers of 20 or more must spend a specified amount (currently ranging from \$1.11 to \$1.60 an hour) on health insurance, health savings accounts, or direct reimbursement of employee medical expenses, or contribute to a public program for the uninsured.

Wellness is a corporate asset. It reduces turnover and absenteeism, it increases productivity and efficiency. Every employer wants it; how can an employer attain it?

II. Today’s Approach: Improving the Health of the Work Force

Faced with rising health care costs, many employers have designed wellness plans designed to encourage their employees to adopt a healthier life style. Employee assistance programs were

an early effort, usually offering assistance to employees dealing with drug and alcohol issues and situational stress. From there, employers began to offer a variety of inducements including cash incentives, discounts on health insurance premiums and lower deductibles, smoking cessation and weight loss programs, gym memberships, and other rewards. No employee was required to do anything, but if an employee was ready to take greater responsibility for his or her health, employers were more than willing to subsidize that effort, all in hopes of reducing health care costs. Today, the continuum has been extended further still, with employers investigating mandatory wellness programs — programs that require the employee to attain and maintain good health as a condition of employment. Obviously, a mandatory program raises significant legal issues and employers must approach them cautiously.

Currently, most employers use a voluntary wellness plan that rewards the employee in some way. Examples include:

Dell Computers deducts \$75 from annual health care premiums for employees who agree to participate in a health-risk assessment, and deposits \$225 in a health expense account for employees who participate in a wellness program.

In 2003, Illinois-Based **International Truck and Engine Corporation** launched the *Vital Lives* program for its 14,500 employees. The mission of the program is “to promote employee accountability to be smart, be healthy, be safe, and be responsible.” Through *Vital Lives*, employees can participate in health screenings, work out in several on-site fitness centers, and receive in-season flu shots. The program is implemented through a corporate wellness council and wellness teams at every operating site. Each local team is made up of union and management volunteers and has an executive sponsor, usually the plant manager. Corporate-sponsored programs such as health risk appraisals and disease management programs are paid through the health plan. The company has established occupational health clinics in many of its manufacturing facilities and its health initiative is channeled into three categories: (1) keeping healthy employees healthy; (2) directing at-risk employees (e.g., those who smoke and/or are overweight) into behavioral change; and (3) directing employees confronting health challenges (e.g., hypertension) into disease

management programs. The company believes that its health initiatives result in savings of \$5 to 6 million per year and, if 100 percent participation were achieved, savings would be in the range of \$20 to \$30 million.

DaimlerChrysler, in conjunction with the United Auto Workers, started its *National Wellness Program* in 1985. The company does not provide the wellness program itself, but contracts with three suppliers. The main goal of the program is to hold employees accountable for their own health. Employees are given a health risk assessment survey. Health promotion professionals target communications and counseling based on results of the survey. A call center is staffed with experts in behavior modification, such as dietitians and exercise physiologists. The company has health and safety professionals who focus on ergonomics, back programs, fitness testing, and individualized exercise programs. A wellness specialist is on-site at every facility with at least 500 employees. The company offers a \$120 health insurance contribution for employees who have a glucose, blood pressure, and cholesterol check once per year.

Pitney Bowes has wellness, medical, and fitness teams. These departments work with each other to create an integrated program to meet the needs and challenges of the workforce. Pitney Bowes has designed a three-component program that is comprised of: (1) *A Healthy Corporation* (corporate culture and values, benefit plans, and management practices conducive to improving health and productivity); (2) *A Healthy Work Environment* (on-site medical clinics and fitness centers, non-smoking worksites, healthy food options, walking routes, a free pedometer program); and (3) *A Personal Responsibility* (education and tools provided for employees to make the healthiest personal choices). Pitney Bowes has also introduced a free prescription drug program in order to help workers manage chronic conditions and avoid paying for more expensive treatments down the road.

Freddie Mac, the nation's second-largest home loan financier, offers the approximately 4,300 employees at its headquarters an on-site clinic, gym, and nutritional services. Additionally, employees who order six healthy meals at the company cafeteria are offered a free seventh meal. The company pays a flat annual fee for the clinic (which is operated by an outside vendor) and

estimates that it saved \$686,000 in direct health care costs in 2005. Because of the clinic's proximity to the workplace, Freddie Mac also saves costs by minimizing employee time lost attending medical appointments. Including this added productivity, Freddie Mac estimates total savings at \$900,000.

Union Pacific Railroad's Health Track program aims to improve its employees' physical and mental health through lifestyle changes and risk reduction. Initiatives such as Union Pacific's *Reduce Obesity Now* are part of *Health Track*. The company offers the program to 47,000 employees and has documented a 34 percent reduction in medical claim costs attributable to "lifestyle issues" over a 10 year period. In addition, Union Pacific has determined through analysis of its own data that certain health risks, including stress, overweight (in the 45+ age category), tobacco use, and perceived health status, are reliable predictors of safety incidents.

Lincoln Plating, a mid-size Nebraska-based manufacturer, experiences health insurance costs 50 percent less than the national average and a 6-to-1 total return on its wellness investment. The program began in the 1970s with a first aid cart and blood pressure checks and continued into the 1980s when the company brought in awareness activities with posters and pop-up tents. In the 1990s, a cross-functional wellness committee was formed, with representatives from departments throughout the company including upper-level managers. The company has a full-time wellness manager, offers testing and intervention, maintains tobacco-free campuses, established a 14,000 foot mountain climb challenge, has wellness performance objectives for each employee, offers free "on the clock" testing for cholesterol, triglycerides, and blood pressure, and offers flexibility tests and body weight analyses. Initial and quarterly consultations are held with the company nurse to discuss individual wellness goals and objectives for the year (if medical problems are suspected, the employee is immediately sent to a physician). Pocket wellness cards are used to record the employee's goals (weight, body fat, etc.) Tobacco cessation programs are offered all year for employees and family members. Employees receive free pedometers. The company has "Wellness Wednesdays," when employees have the option of engaging in fitness activities. Gym memberships are reimbursed, and activities for family members such as child

swimming lessons are also reimbursed. Everyone receives the Mayo Clinic *Health Letter*.

GE Energy encourages its workforce to take personal responsibility for their risk of cardiovascular disease and diabetes. The Health Services Team seeks to motivate, coach and support every beneficial effort employees make. The *Health By Numbers Program* (0-5-10-25), launched in 2001, advocates zero tobacco use, five daily servings of fruits and vegetables, 10,000 steps per day (or 30 minutes of moderate physical activity), and striving for a body mass index (BMI) of less than 25. Using extensive web-based programs, outreach, and conferences at on-site locations, the program is available in seven languages and is established at all GE Energy locations. A cardiovascular/diabetes risk assessment and an online monthly motivational nutrition, exercise and BMI tracking program including personal coaching are integral to the program's success.

Ottawa Dental Laboratory provides a program whereby employees earn "bucks" from the company's health insurer's website for exercising, or quitting smoking. Bucks are redeemable for anything from iPods® to DVDs.

While most employers report the great success of these programs, some question their effectiveness. Voluntary plans appeal to persons who already have healthy lifestyles; gym memberships are attractive to people who like to work out, not those who hate exercise. It is unclear whether the employees with the worst health habits benefit. At least one program backfired: the company offered cash incentives for employees who quit smoking, only to find out that some nonsmokers started smoking just to qualify for the extra cash.

III. Tomorrow's Challenge: Mandating Employee Wellness

A. What Is a Mandatory Wellness Plan

A mandatory wellness plan requires the employee to participate and, if an employee does not, imposes some penalty. At one company, to be eligible for health insurance coverage, an employee must take a health risk assessment and undergo blood pressure and cholesterol screening. The employee's premium is not dependent on the results of the tests, but 17 employees lost their health coverage because they declined to participate. Some mandatory plans not only require employees to take a health risk assessment, but take the extra step of assigning professional "health coaches" who draw up action plans and follow up to see that the employees are on plan.

B. Examples of Mandatory Plans

Scotts Miracle-Gro has implemented one of the first large-scale mandatory wellness programs, including a ban on tobacco use for those employees working in states where such a prohibition is permitted. The ban includes not only tobacco use in the workplace, but at home as well. Tobacco use testing is required of all new hires and is done randomly on the existing workforce; the presence of nicotine is grounds for termination of employment. (A lawsuit challenging this aspect of the program is currently pending.) Employees are urged to take exhaustive health-risk assessments. Those who balk pay \$40 a month more in premiums. Using an outside management company, analysts scour the physical, mental, and family health histories of nearly every employee and cross-reference that information with insurance claims data. Health coaches identify which employees are at moderate to high risk. All employees are assigned a health coach who draws up an action plan. Those who do not comply pay \$67 a month on top of the \$40. Scotts built a 24,000 sq. ft, \$5 million medical and fitness center across the street from headquarters, staffed by two full-time doctors, five nurses, a dietician, counselor, two physical therapists, and a team of fitness coaches, with a drive-thru pharmacy for free prescription drugs.

Cadmus Communication Corp., a publishing services corporation, requires workers and their covered spouses to undergo mandatory health — risk assessments to qualify for medical coverage. The assessment consists of an online questionnaire, a blood-pressure check and a finger-prick blood test for cholesterol. Results of the tests are only shared with Cadmus' health insurer and do not lead to punitive premiums. As part of the plan, employees received some new perks including additional low-cost screenings, on-site mammograms, low-cost flu shots, and subsidized visits to a nutritionist.

Is this legal? How far on the voluntary — mandatory continuum can employers go? There is little case law to provide guidance, and the answer will vary from state to state, but Littler believes that employers who carefully design a mandatory wellness plan will reap rewards that merit taking some risks.

IV. Legal Challenges Presented By Mandatory Wellness Plans

Any wellness program that is not carefully drafted and implemented is likely to be found in violation of at least one of the many applicable federal and state laws. Two that come immediately to mind are the Health Insurance Portability and Accountability Act (HIPAA), with its stringent requirements for ERISA-covered health plans, and the Americans with Disabilities Act (ADA) and equivalent state statutes. Because, as a general rule, health declines as employees age, the Age Discrimination in Employment Act (ADEA) and equivalent state laws certainly must be considered. Title VII and equivalent state laws prohibit discrimination on the basis of gender and religion, issues that may arise with some wellness programs. Bargaining obligations under the National Labor Relations Act (NLRA) must be respected when employees are represented by a union. State privacy laws and statutes prohibiting restrictions on lawful off-duty conduct have to be considered. And last, but not least, public entities have unique constitutional concerns.

A. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

On December 13, 2006, the Employee Benefits Security Administration, Department of Labor, and Internal Revenue Service issued final regulations relating to wellness programs.¹² These new regulations, which will apply in any plan year beginning on or after July 1, 2007, are applicable to both voluntary and mandatory wellness plans. While the regulations will govern what an employer may or may not do under a wellness plan, they do not prohibit wellness plans themselves.¹³ Any employer with a wellness plan, or contemplating a wellness plan, should consult legal counsel to determine how these new regulations will impact the existing or contemplated plan. We highlight the significant rules here.

Generally, HIPAA prohibits ERISA group health plans (and virtually every employer health plan is an ERISA plan) from discriminating based on a health factor. Health factors include, but are not limited to, health status, medical condition, claims experience, receipt of health care, and medical history. As examples, nicotine addiction and body mass index are considered health factors covered by the HIPAA non-discrimination rules. The HIPAA non-discrimination rules prevent group health plans from providing incentives based on the absence or existence of a health factor.

1. Wellness Programs that Do Not Provide a Reward Based on a Health Factor Generally Are Considered Non-Discriminatory Under HIPAA

Wellness programs that do *not* provide a reward based on a health factor do not, by definition, discriminate based on a health factor. For example, *an incentive that is conditioned on participation in a health program, rather than achievement of particular health target or standard*, generally is not discriminatory under HIPAA.¹⁴ Incentives that are conditioned on participation (rather than results) include: a program that reimburses the cost for membership in a health center; a program that provides a reward to employees for attending a monthly health education seminar; an incentive to participate in a cholesterol, blood pressure, or other screening program that is paid regardless

¹² 26 C.F.R. §54.9802-1 *et seq.*

¹³ 26 C.F.R. §54.9802 *et seq.*

¹⁴ 26 C.F.R. §54.9802-1(f)(1).

of outcome; and reimbursement for participation in weight loss and smoking cessation programs that is paid regardless of outcome. Wellness programs that do not provide a reward based on a health factor need not meet the five requirements described below.

2. Wellness Programs that Provide a Reward Based on a Health Factor Must Meet Certain Requirements to Be Considered Non-Discriminatory Under HIPAA

The new regulations mandate that programs that provide a reward based on a result must meet certain requirements to be non-discriminatory. Examples of wellness programs that provide a reward based on results include: providing a reward only if an individual reduces cholesterol below a certain score; providing a reward only if a certain target body mass is achieved; and providing a reward only if the individual does not smoke. Five requirements must be met for such programs to meet HIPAA non-discrimination requirements:

- a. the total reward that may be given to an individual cannot exceed 20 percent of the total cost of employee-only coverage;
- b. the program must be reasonably designed to promote health or prevent disease;
- c. the program must allow eligible individuals the opportunity to qualify for the reward at least annually;
- d. the program must be available to all similarly-situated individuals. To meet this requirement, the program must allow: (a) a reasonable alternative standard for individuals whose medical conditions would make attaining the standard unreasonably difficult; and (b) a reasonable alternative standard for individuals with medical conditions that would make medically inadvisable attempts to satisfy the basic standard. Group plans may verify through the participant's physician that a health factor makes attaining the basic standard either unreasonably difficult or medically inadvisable.

- e. all plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard or the possibility of waiver of the applicable standard.¹⁵

An example of a wellness program that meets these requirements is a group health plan that waives the annual deductible (which is less than 20 percent of the annual cost of employee-only coverage) for the following year for participants who have a BMI between 19 and 26, determined shortly after the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition or medically inadvisable to attain this standard during the plan year is given the same discount if the participant is able to reduce his or her BMI by at least a point. If the alternative standard is either is either unreasonably difficult due to a medical condition to attain, or medically inadvisable to attempt to achieve during the year is given the same discount if the individual satisfies a reasonable alternative standard that is tailored to the individual's situation, for example, walking 20 minutes a day three times a week or adhering to a reduced daily caloric intake. All plan materials describing the terms of the wellness program should include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a BMI between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this BMI) this year, your deductible will be waived if you are able to reduce (or, if below 19, increase) your BMI by at least a point. If it is unreasonably difficult due to a medical condition or medically inadvisable for you meet this alternate standard, we will work with you to develop another way to have your deductible waived, such as a walking program or dietary regimen."¹⁶

3. Sample Wellness Plans that Comply with the HIPAA Wellness Plan Regulations

The legislative history supporting the new HIPAA regulations include samples of wellness plans that would be in compliance, including:

¹⁵ 26 C.F.R. §54.9802-1(f)(2)

¹⁶ 26 C.F.R. §54.9802-1(f)(3), Ex. 4.

- The employer offers a wellness program that requires employees to walk or exercise for 20 minutes a day, three times a week, on paid time. If an employee is unable to walk or exercise, a reasonable accommodation is provided by having the employee engage in stress-reduction techniques for 20 minutes a day, three times a week, on paid time.
- The wellness program consists solely of an annual screening for cholesterol, hypertension, and weight. Employees are told they must have their cholesterol, blood pressure, and weight within stated norms. If it is unreasonably difficult for an employee to achieve the targets, or if it is medically inadvisable for the employee to attempt to reach those goals, a reasonable alternative is provided that requires the employee to begin a diet and exercise program, even if the program will not bring his or her levels within the stated norms.
- The wellness program prohibits smoking at any time and location where the employee is working. Beyond that, it offers incentives for employees to participate in smoking cessation programs and subsidizes the cost of nicotine substitutes. If the employee is unwilling to participate in a smoking cessation program, the employee is required to view, on paid time, a video on the health problems associated with tobacco use. An employee can be disciplined for smoking when at work, but is not subject to disciplinary action if he or she does not stop smoking completely, or chooses to watch the video rather than participate in the cessation program.
- The employee's health assessment reveals hypertension. The employee is unable or unwilling to exercise, but will agree to participate in a program of relaxation techniques, to include aromatherapy massages (for which the company will pay).
- All employees are required to undergo health screenings on an annual basis and employees

receive paid time off (or some other incentive) if they also undergo recommended diagnostic testing as appropriate (PAP smears, mammograms, prostate exams, etc.) with the company paying any deductible or co-pay associated with the tests. No employee is required to do anything more or to undergo any medical treatment.

B. Discrimination Against Persons with Disabilities

Under the ADA, an employer may not discriminate against a qualified individual with a disability with regard to, among other things, employee compensation and benefits available by virtue of employment.¹⁷ ADA issues will arise in a mandatory wellness program for three reasons. First, the ADA limits the circumstances under which an employer may ask questions about an employee's health or require the employee to have a medical examination. Second, the ADA imposes strict confidentiality requirements on the disclosure of medical information. Third, the ADA will certainly apply if an employee is able to perform the essential functions of his or her job but, because of a disability, is unable to achieve a health factor requirement under a mandatory wellness plan.

Medical inquiries or examinations of current employees regarding the existence, nature or severity of a disability are generally prohibited unless job-related and consistent with business necessity.¹⁸ All employees are entitled to this ADA protection; (i.e., they do not have to be a qualified individual with a disability).¹⁹ To avoid the first and second ADA obstacles, most employers who adopt wellness plans retain an independent third party to administer the program. The third party administrator collects and analyzes all medical information and does not disclose individual health data to the employee.

The EEOC has taken the position that it is permissible to ask medical information as part of a voluntary wellness program that focuses on early detection, screening, and management of disease.²⁰ A wellness program is "voluntary" as long as an employer neither requires participation nor penalizes employees who do not participate.²¹ Information collected during the permissible inquiries or examinations must be maintained in separate medical files and treated as confidential medical information.²² While the EEOC's position implicitly suggests that it would not

¹⁷ 42 U.S.C. §12112(a), (b).

¹⁸ 42 U.S.C. §12112(d)(4)(A).

¹⁹ See, e.g., *Fredenburg v. Contra Costa Co. Dep't of Health Servs.*, 172 F.3d 1176, 1182 (9th Cir. 1999); *Conroy v. New York State Dep't of Corr. Servs.*, 333 F.3d 88, 94 (2d Cir. 2003).

²⁰ 42 U.S.C. §12112(d)(4).

²¹ *Enforcement Guidance: Disability-Related Inquiries And Medical Examinations Of Employees Under The Americans With Disabilities Act (ADA)*, available at www.eeoc.gov/policy/docs/guidance.

²² 42 U.S.C. §12112(d)(3)(B), (4)(C).

reach the same conclusion for a mandatory wellness program, as long as the mandatory program only requires the employee to participate in a health assessment and does not require the employee to achieve any specific health standard and only the third party administrator has the individual's medical data, the same conclusion should be reached.

But what if the wellness plan mandates that employees achieve some measurable health standard as a condition of employment? While at the riskier edge of the wellness continuum, the concept of a reasonable accommodation, both under the ADA and the HIPAA regulations, suggests that even the third obstacle can be overcome. The employee may be able to meet a less stringent health factor or be given the alternative of participating in a program designed to manage or mitigate the medical condition. If a physical or mental disability prevents an employee from participating in such an alternative, and the employee is able to perform the essential functions of the job, a waiver may be necessary. Obviously, an employer who learns of an otherwise undisclosed and unapparent disability as a result of a mandatory health assessment will need to take extra precautions to assure that the knowledge obtained in the health assessment truly is not used as the basis for an adverse employment action.

Employers should also be mindful that not all at-risk health conditions are tied to a disability. An employee's excess weight may be tied to poor diet and exercise habits, not an endocrine imbalance. Smoking, excessive drinking (short of alcoholism), and recreational drug usage (short of addiction) are poor health habits that are not per se protected by the ADA.

An employer might also argue that the wellness program does not discriminate on the basis of disability, because its terms apply equally to disabled and nondisabled. This defense has been discussed in a handful of cases with respect to employee benefits plans.²³ The employer might also defend an ADA claim by arguing that the wellness program was implemented for underwriting, classifying or administering risks.²⁴ However, an employer may not use risk-assessment activities as a subterfuge to evade the ADA's nondiscrimination requirements (e.g., refusing to hire disabled persons solely because their disabilities may increase the employer's future health care costs; or denying disabled employees

equal access to health insurance based on disability alone, if the disability does not pose increased insurance risks).²⁵

C. Age Discrimination in Employment Act (ADEA)

A mandatory wellness program can be crafted that corresponds to the reasonable expectations of the older worker. Wellness programs do not demand that employees become super athletes or achieve perfect health. If a mandatory program requires an employee to achieve a certain health standard, that standard should take into account, and if necessary, be adjusted for, the age of the employee. Programs can mandate participation in an exercise or fitness program without requiring that everyone be able to run a certain distance at a certain speed.

D. Title VII

In addition to age, some of the classes protected by Title VII and similar state laws may be implicated in a mandatory wellness program. Gender and religion come to mind, but again, reasonable accommodation should lessen the risk of litigation.

If specific health standards are set, an employer must be able to objectively demonstrate with reliable expert data that the standards do not discriminate against women. In the early 1980s, many airlines' weight limitations for flight attendants were challenged because they were overly restrictive when it came to women, allowing more tolerance for excess weight in male flight attendants. Wellness programs should set goals based on what is a healthy weight, even if a female employee might look more attractive if she were thinner than that. There are generally accepted BMI standards based on age and gender that could be incorporated into a wellness program. Women carry a greater percentage of body fat than do men and that is factored into the BMI.

Religion would be a challenge if, in order to manage a health risk, an employee should be on medication but, for religious reasons, the employee does not take medication. If medication were the only way the employee could achieve a stated health standard, a reasonable accommodation would have to be offered. For example, an employee with high blood pressure may not be able to get his or her pressure into a normal range without medication, but may be able to reduce it somewhat with diet and exercise, even though it remains over desired levels.

²³ *Krauel v. Iowa Methodist Med. Ctr.*, 915 F. Supp. 102 (S.D. Iowa 1995) (health plan's exclusion for infertility treatments was not a distinction based on disability, because it applied to individuals who did and did not have disabilities); *EEOC v. Staten Island Sav. Bank*, 207 F.3d 144 (2d Cir. 2000) (in the context of a long term disability plan, offering different benefits for mental and physical disabilities does not violate the ADA, because every employee was offered the same plan regardless of disability status).

²⁴ 42 U.S.C. §12201(c)(2), (3).

²⁵ 42 U.S.C. §12201(c)(2). See, e.g., *Barnes v. Benham Group, Inc.*, 22 F. Supp. 2d 1013 (D. Minn. 1998) (holding in favor of the employer on an ADA claim, where the employer terminated an employee who refused to complete a health insurance enrollment form, because the form was used by the insurer to classify or underwrite risk); *McLaughlin v. General Am. Life Ins.*, 1998 U.S. Dist. LEXIS 16994 (E.D. La. Oct. 21, 1998) (preexisting condition limitation excluding payment of claims for which the insured had been treated during the last 12 months did not violate ADA).

E. National Labor Relations Act

Employers in a unionized environment may also face significant challenges in implementing a wellness program. According to the NLRA, employers must bargain in good faith over “mandatory subjects of bargaining,” defined to include wages, hours, and other terms and conditions of employment. Given that many wellness programs are likely to impact an employee’s wages (via reduced health premiums) and mandatory programs certainly will impact the terms and conditions of employment, an employer in a union environment most likely will not be able to unilaterally implement a wellness program. Rather, such employers likely will be required to propose their wellness program to the union and engage in bargaining over the terms of the program.

Employee benefits such as health insurance plans are mandatory subjects of bargaining.²⁶ Thus, should an employer’s wellness program change the structure of employee contributions, co-pays, and deductibles or offer new programs on topics such as smoking cessation and weight loss, the employer will likely be required to bargain over such changes.

In addition, the National Labor Relations Board (NLRB) has also held that health and safety issues are also mandatory subjects of bargaining. For example, the Board has held that an employer must bargain over its implementation of a non-smoking policy.²⁷ Thus, should an employer’s wellness program seek to restrict on-site use of tobacco products, the employer will likely need to bargain with the union over such a decision.

Some wellness programs might also require that employees submit to physical examinations. These aspects of the program must also be bargained with a union.²⁸ Accordingly, cholesterol, blood pressure, and other types of physical examination programs are likely mandatory subjects of bargaining. Even an employer’s decision to significantly change dining alternatives in its cafeteria may also trigger its duty to bargain with the union, particularly where services are altered or prices affected.²⁹

Therefore, an employer in a union environment should consider these obligations in conjunction with its overall bargaining strategy. The experience of DaimlerChrysler/United

Auto Workers program may set a precedent that other unions will be more than willing to follow.

F. Privacy and Other Statutes

A number of states have enacted laws that must be considered when designing a mandatory wellness program. While this is not an all-inclusive list of every state statute that might be triggered by a wellness program, it should serve as an important reminder to engage local counsel in the states where you as an employer do business in the process of designing and implementing any wellness program.

1. State Health Information Privacy Statutes

California, Hawaii, Maine, Maryland, Minnesota, and Wisconsin have comprehensive statutory schemes regulating how employers may use and disclose employee health information. As one example, California’s statute requires employers to establish procedures to protect the confidentiality of an employee’s medical information and limits how employee health information may be used and disclosed without the employee’s authorization. The latter requirement would bar the disclosure to managers of health information generated by a mandatory wellness program. Moreover, employers are barred from retaliating against an employee who refuses to sign an authorization for disclosure although an employer may take actions necessitated by the lack of information resulting from the employee’s refusal. The statute also imposes requirements on the form and content of an authorization. Employers in these states may have to use a third party administrator to conduct their wellness programs.

2. State Laws Prohibiting Adverse Action on the Basis of Lawful Off-Duty Conduct

A growing number of states have enacted statutes prohibiting employers from taking adverse employment action for lawful off-duty conduct. While using tobacco or drinking too much is unhealthy, it is not illegal. In these states, employers must be careful not to implement

²⁶ *Hardesty Co., Inc. d/b/a Mid-Continent Concrete Co.*, 336 NLRB 157, enforced 308 F.3d 859 (8th Cir. 2002) (employer violated 8(a)(5) by unilaterally changing the health insurance benefit plan); *Brook Meade Health Care Acquirers*, 330 NLRB 775 (2000) (unilateral increase in employee contributions to health insurance premiums constitutes a violation of the NLRA).

²⁷ *See-Tech Corp.*, 309 NLRB 3 (1992), *aff’d sub nom. NLRB v. High Tech. Cable*, 25 F.3d 1044 (5th Cir. 1994) (management rights provision relied on by employer not sufficient to constitute clear and unequivocal waiver of union’s right to bargain over specific no-tobacco rule); *Allied Signal, Inc.*, 307 NLRB 752 (1992) (union’s agreement to “safety and health” clause was deemed conscious waiver of union’s right to bargain prior to employer’s implementation of new policies affecting health and safety, such as change in smoking policy).

²⁸ *Colgate-Palmolive Co.*, 323 NLRB 515 (1997); *Leroy Mach. Co.*, 147 NLRB 1431 (1964) (management-prerogatives clause constituted union waiver of right to require employer to bargain about physical examinations during term of existing agreement).

²⁹ *Mercy Hosp. of Buffalo*, 311 NLRB 869 (1993) (elimination of late night cafeteria service); *O’Land, Inc.* 206 NLRB 210 (1973) (employer violated section 8(a)(5) by unilaterally granting free meals to non-striking employees; the employer failed to notify employees that the free meals were a temporary measure for the purpose of protecting nonstriking employees).

mandatory wellness programs, or even target goals within those programs, that permit adverse employment action based on an employee's failure to abstain from smoking. In several states (Colorado and New York, for example), the prohibition extends to virtually any lawful off-duty conduct that does not conflict with the employer's interests. Thus, an employer could not take adverse action in those states against an employee who overeats while off-duty and cannot meet weight-loss objectives.

The scope of these state laws should be examined carefully before a mandatory wellness program is put in place so that an employer can determine the types of "carrots and sticks" that would be permissible. Colorado's statute, for example, prohibits termination based upon lawful, off-duty conduct, but does not bar other types of adverse employment action. Thus, discipline short of termination based on employees failure to conform off-duty conduct to wellness program requirements might be permissible even in states that provide protections for lawful off-duty conduct.

3. State Laws Prohibiting Adverse Action Based on the Results of Genetic Testing

Employers implementing mandatory wellness programs that include genetic testing must also comply with a myriad of state laws. More than one-half of all states have implemented statutes regulating whether and how employers may obtain, use, and disclose genetic information.

By way of example, Massachusetts has enacted a comprehensive genetic testing statute. The statute bans genetic testing without informed consent and further requires written consent for the disclosure of any reports or other records containing genetic information. Massachusetts' law goes so far as to establish that genetic composition is a protected characteristic under the state's anti-discrimination statute. Hence, in Massachusetts employers must be careful before implementing an employee medical screening initiative that evaluates an employee's propensity for genetically linked medical conditions, such as sickle cell anemia or certain types of cancer.

Due to the diversity among state laws, multi-state employers, in conjunction with experienced counsel, should evaluate the effect of state genetic testing laws before implementing a mandatory wellness program.

G. Constitutional Concerns for Public Entities

The Eastern District of Michigan has been one of the first courts to address a wellness program. *Anderson v. City of Taylor*, 2006 U.S. Dist. LEXIS 38075 (E.D. Mich. June 9, 2006), the City of Taylor Fire Department implemented a wellness program that included a free membership for each employee to the city's recreational facility, free rounds of golf at the city-owned golf courses, and blocks of ice time at the city's arena, and a health appraisal. The health appraisal included a mandatory blood draw, which was used to determine cholesterol level. The plaintiff firefighters sued, claiming that the blood draws violated their constitutional rights, including their Fourth and Fourteenth Amendment rights to be free from unreasonable searches and seizures. The union filed a grievance on behalf of the plaintiffs, stating that the blood draw violated their collective bargaining agreement. The court denied the city's motion for summary judgment and, as a result of the union's grievance, the fire department abandoned the blood draws.

V. Model Mandatory Wellness Programs

A. Preparing to Design & Implement a Mandatory Wellness Program

There is "no one size fits all" wellness program. The first step in designing a plan is assessing the specific health issues that employees at your worksites face, and determining which issues may be best addressed through a legally-compliant wellness program. Working with a health administrator, a thorough audit of why the company is spending health dollars should be conducted. One company conducted a year long audit of its employees' health insurance claims to determine what health issues needed to be addressed. The results were divided into two categories: chronic conditions that needed to be better managed, and non-chronic problems that could be changed. In the category of chronic conditions the top five were (in descending order) depression, asthma, back pain, diabetes, and cardiac illnesses. Fitness, weight

loss, cholesterol, hypertension, and tobacco use took the honors in the non-chronic classification. With depression and fitness in first places, an exercise program was clearly indicated, but more emphasis was placed on emotional health (positive stress management techniques) than the employer had anticipated when it first set out to design the program.

The audit should also include an analysis of who are your employees and what they do. This may sound obvious, but it is essential. What is the average age of your workforce? Do they perform manual labor or sedentary desk jobs? Are they compensated at levels that allow discretionary income for gym memberships? Do they work shifts at times when it is more difficult to eat at restaurants that offer healthy choices? Do they have access to refrigerators and microwaves where they might store and prepare healthier meal choices? Are there gym facilities at the workplace? Do these include showers and lockers for clothing? Is there towel service?

The next step is education. Wellness programs have a “big brother” aspect to them and employers who do not pre-educate their employees will find some of them challenging what is perceived as an invasion of privacy. The CEO of one employer engendered the support of employees by showing them a PowerPoint presentation which revealed that the company’s health care bill had increased 42 percent in only four years and amounted to 20 percent of the company’s net profits; money that could not be put toward wages, or sales, or product development.

Another company had employees conduct a self-assessment. Although 23 percent of the employees thought they were overweight, in reality, 78 percent fell in that category. When the employees realized the disparity between their perceptions and reality, they were more willing to invest in a wellness program. Employees will acknowledge they think they know what they should do to be healthier, but admit that they need more education and support to put what they know into action.

Employees have to buy-in to the program to make it work (and forestall lawsuits). If it is perceived solely for its negative aspects, (e.g., higher insurance premiums for employees who do not participate in fitness programs), the program will meet with resistance. Wellness programs should be presented as a positive:

participation will mean a lower premium and the employer will support the employees’ efforts by providing the tools needed to get healthy. You can tell an employee to exercise or you can provide a fitness center or subsidize a gym membership. At Scotts, employees who use the fitness center are known as “gym rats” and earn pins they display on their ID badge lanyards; the pins have become status symbols.

An employer who looks for creative, diverse ways of promoting wellness is likely to be more successful in getting employees to participate in the program than one who uses only punitive measures with unhealthy employees. Achieving a healthy work force will typically require a substantial change in culture and attitudes. But there is a “build it and they will come” factor as well. Companies who offer fitness centers, healthy food, and rewards for good health habits will attract employees who take care of their health.

Wellness should become a part of the corporate culture. Morning meetings should be accompanied by fruit and low-fat granola bars, not bagels and cream cheese, or even worse, doughnuts and high-calorie muffins. Cafeterias should offer healthful choices and snack machines and soda machines should be thoughtfully stocked. A large bowl of fruit that employees can grab as they walk by might warrant prominent placement. Do not just tell employees they should drink more water; make sure water is readily available. Feature bottles of water at company lunches and meetings instead of carbonated soda drinks. During the summer months, one large metropolitan office building invites organic produce vendors to sell their wares on the building’s plaza.

B. Sample Programs

Here we offer for consideration two mandatory wellness programs, one very conservative in approach, the other to the far right of the continuum. These are not model programs, rather they are intended to provoke thought and discussion.

1. The Conservative Mandatory Wellness Program

All employees are required to participate in one hour of mandatory interactive online health and fitness education each month. Employees are provided with online access and may log on during working hours. All employees

are guaranteed at least one hour of uninterrupted time for this purpose. Employees' participation is monitored electronically. An employee who does not actively participate each month is subject to disciplinary action. An employee who misses one month is given a written warning, an employee who misses two months is ineligible for a merit salary increase, and an employee who misses three months in a calendar year will be terminated.

Variations on this program abound. The education modules may be presented by live presenters. Employees may be required to tour the company's fitness facility with a trainer who will show them the various equipment and how it should be used. Employees are required to engage in at least one hour of stress reduction each week and the company makes available quiet rooms, relaxation tapes, video tapes, aromatherapy areas, biofeedback tapes, and exercise equipment, all of which can be used on company time.

It may seem silly to pay an employee to watch a video on the health hazards of smoking, or to meditate, or to have an aromatherapy massage. (Each of these alternatives is suggested in the legislative history to the new HIPAA regulations.) But if depression and stress are the number one chronic health conditions in the workplace, the cost of educating an employee how to deal with that depression and stress will be offset by the greater productivity and loyalty of an employee who is not depressed and stressed. The expectation is that an employee who is educated about his or her health, and offered the tools to manage, alleviate, or eliminate the health issue, will do exactly that.

2. The "Get Healthy or Get Out" Mandatory Wellness Program

Using the services of an independent third-party provider, all employees are required to undergo a health assessment. If that assessment indicates blood pressure, cholesterol, and/or a BMI above desirable ranges, the employee is required to get their blood pressure, cholesterol, and BMI within desirable ranges. Each at-risk employee is assigned a health professional who will tailor

an individual plan suited to the employee's lifestyle and preferences, with a reasonable time period for reducing his or her blood pressure, cholesterol, and/or BMI. The employee who reaches desirable numbers is provided with an incentive that meets the HIPAA guidelines in the form of reduced insurance premiums. An employee whose medical conditions make attaining desirable norms unreasonably difficult or medically inadvisable is provided a reasonable alternative determined after consultation with the employee's health care provider. For example, the employee may be required to reduce his or her blood pressure, cholesterol, and/or BMI by 10 percent, even though that will still be above desirable norms. If it is determined that an employee can only reach this standard with medication, and the employee objects to taking medications, a waiver is given.

The employer is told which employees have been identified as at-risk, but not the reason or any of the underlying medical conditions. Periodic reports are made to the employer, indicating only whether or not the employee is complying with the individual remediation plan.

To assist the employee, the employer provides a state of the art fitness center that the employee may use for up to one hour a day three times a week during paid time. The employee may make unlimited use of the facility on his or her own time and the fitness center is opened both before and after working hours. The employee's health coach assures that the employee is trained in the proper use of the equipment and which exercises are best for him or her. This employer also has a "healthy-only" cafeteria and snack machines and offers a variety of stress-reduction programs for employees.

Another situation that can occur is where the employee refuses to exercise and there is no medical reason or disability which prevents him or her from exercising. The employee simply does not like to exercise. The health coach draws up an alternative plan that focuses on diet and nutrition. The employee continues old, unhealthy eating habits. No progress is made.

What happens next? This employee is warned, not once, but progressively, that, in order to maintain profitability and provide for the common good, an employee who is medically able to attain reasonably established norms for desirable blood pressure, cholesterol, and weight is expected to do so. The employee simply declines to address his or her health issues. The employee is terminated.

Yes, there will be litigation, but is it inconceivable that the employer might prevail?³⁰

VI. Future Developments Addressing Wellness Programs

A. State and Federal Wellness Related Proposed Legislation

Perhaps recognizing that widespread employer wellness programs are inevitable, Congress and many state legislatures have begun addressing the issue of employee wellness in proposed legislation. Although the legislation ranges in scope and specifics, it is clear that state legislatures have noticed the increasing trend towards employee wellness and the benefits associated with such programs.

Some states, recognizing the trend towards wellness programs that seek to reduce or eliminate smoking and obesity, have moved towards providing additional protections for employees. Massachusetts legislators have proposed adding height and weight as protected classes for purposes of discrimination in employment and housing.³¹ If passed, Massachusetts will join Michigan, the District of Columbia, Santa Cruz, California, and San Francisco, California as locations that have prohibited discrimination on the basis of weight.

On the smoking front, legislators from the State of Washington have moved to protect smokers, introducing legislation making

it specifically unlawful for an employer to require an employee or applicant for employment to disclose, verbally or in writing, whether or not he or she has consumed lawful tobacco products at any time before or during employment with the employer.³² Additionally, Washington employers would be prohibited from asking current or prospective employees to agree verbally or in writing not to consume lawful tobacco products off the premises of the employer during non-work hours. However, under the terms of the proposed bill, employers legally may require an applicant or prospective employee to disclose consumption of tobacco products or agree not to consume such products under the terms of an employer's insurance policy or wellness program, as otherwise permitted by law.³³ This exception does not cover current employees; thus, the legislation would make it unlawful for employers to inquire into a current employee's tobacco usage or to require employees to agree to stop smoking.

New Mexico, on the other hand, has introduced legislation that would allow the director of insurance to enter into an agreement with small employers to provide health care coverage only if the small employer has a policy prohibiting the hiring of individuals who smoke or use tobacco products.³⁴ Moreover, the small employer must have had the policy in place for at least one year in order to be eligible.³⁵ Thus, the New Mexico bill implicitly endorses policies prohibiting the employment of smokers and tobacco users.

Smoking in the workplace has attracted perhaps the most attention from the states. Numerous states have introduced legislation designed to prohibit or more strictly regulate smoking in workplaces and public places.³⁶ Massachusetts legislators recently introduced a bill that would provide coverage for the cost of nicotine based and non-nicotine based smoking cessation products.³⁷ Similarly, Indiana introduced legislation covering

³⁰ The above example is simply an illustration of one possible wellness program in the future. We do not mean to suggest that this program is consistent with current legal standards, and no employer should implement such a program without first consulting legal counsel. However, we present this model because we believe it is conceivable that as the nation addresses the wellness crisis there may be legislative and judicial support for such a radical approach.

³¹ H.R. 1844, 185th Gen. Crt., Reg. Sess. (Mass. 2007).

³² H.R. 1154, 2007 Leg., Reg. Sess. (Wash. 2007).

³³ *Id.*

³⁴ S. 663, 48th Leg. 1st Sess. (N.M. 2007).

³⁵ *Id.*

³⁶ See, e.g., S. 155, 2007 Leg., Reg. Sess. (Ala. 2007); R.45, 2007 Council, Reg. Sess. (D.C. 2007); B. 187, 2007 Council, Reg. Sess. (D.C. 2007); H.S.B. 24, 2007 Gen. Assem., Reg. Sess. (Iowa 2007); S. 36 2007 Gen. Assem., Reg. Sess. (Iowa 2007); H. 246, 95th Gen. Assem., Reg. Sess. (Ill. 2007); S. 500, 95th Gen. Assem., Reg. Sess. (Ill. 2007); H. 305, 85th Leg., Reg. Sess. (Minn. 2007); S. 238, 85th Leg., Reg. Sess. (Minn. 2007); H. 316, 2007 Leg., Reg. Sess. (Miss. 2007); S. 2573, 2007 Leg., Reg. Sess. (Miss. 2007); H. 259, 2007–2008 Gen. Assem., Reg. Sess. (N.C. 2007); S. 365, 2007–2008 Gen. Assem., Reg. Sess. (N.C. 2007); S. 2164, 60th Leg., Reg. Sess. (N.D. 2007); L. 395, 100th Leg., 1st Sess. (Neb. 2007); H. 1332, 51st Leg., 1st Sess. (Okla. 2007); H. 2016, 74th Leg. Assem., Reg. Sess. (Ore. 2007); S. 354, 74th Leg. Assem., Reg. Sess. (Ore. 2007); H. 720, 2007 Gen. Assem., Reg. Sess. (Pa. 2007); S. 246, 2007 Gen. Assem., Reg. Sess. (Pa. 2007); H. 5685, 2007 Gen. Assem., Jan. Sess. (R.I. 2007); H. 119, 105th Gen. Assem., Reg. Sess. (Tenn. 2007); S. 69, 105th Gen. Assem., Reg. Sess. (Tenn. 2007); H. 9, 80th Leg., Reg. Sess. (Tex. 2007).

Currently, eight states — Delaware, Hawaii, Massachusetts, New Jersey, New York, Ohio Rhode Island and Washington — and the District of Columbia prohibit smoking in all workplaces, restaurants and bars. Five states — California, Colorado, Connecticut, Maine and Vermont — prohibit smoking in all restaurants and bars. Four states — Florida, Louisiana, Nevada and Utah — prohibit smoking in all workplaces and restaurants. Arkansas and Idaho prohibit smoking in all restaurants. Additionally, Montana, North Dakota and South Dakota prohibit smoking in all private workplaces.

smoking cessation products.³⁸ Tennessee has introduced legislation allowing each department and agency of the state to elect to provide a smoking cessation program for state employees.³⁹ If the department or agency elected to provide a smoking cessation program, each employee would be eligible to have the cost of one attempt to quit smoking covered by the state.⁴⁰

Smoking in the workplace has also impacted workers' compensation laws of various states. At one end of the spectrum, a bill has been introduced in Colorado that would prohibit payment of workers' compensation benefits for injuries caused by involuntary exposure to second-hand tobacco smoke.⁴¹ And at the opposite end, New York legislators introduced a measure that would extend the time period during which an employee could file for workers' compensation benefits for occupational exposure to tobacco smoke.⁴² Under the bill, employees have two years from the time when the employee knew or should have known that the disease was caused by the nature of the employment.⁴³ Rhode Island's legislation would require employees to sign an authorization confirming that they work in an establishment that permits smoking and that such smoke may be hazardous to the health of employees.⁴⁴

Wellness programs also are receiving attention. The federal House of Representatives is currently considering legislation that would offer employers tax credit if the employer implements a wellness program.⁴⁵ To qualify for the tax credit, the program must:

- be implemented by the eligible employer in consultation with an individual who has implemented a wellness program for a different employer and who will ensure compliance with appropriate measures to protect the privacy of program participants;
- conduct health risk assessments for each of the program's participants;

- offer at least 2 of the preventive services strongly recommended by the U.S. Preventive Services Task Force on an annual basis;
- offer annual counseling sessions and seminars related to at least 3 of the following: (1) smoking, (2) obesity, (3) stress management, (4) physical fitness, (5) nutrition, (6) substance abuse, (7) depression, (8) mental health, (9) heart disease, and (10) maternal and infant health; and
- have at least 50 percent of the eligible full-time employees participate in the program.⁴⁶

Congress is also concerned with the use of information generated as part of a wellness program. Both the Senate and House of Representatives are considering bills entitled the "Genetic Information Nondiscrimination Act of 2007."⁴⁷ Under both versions of the bills, employers are prohibited from requesting, requiring, or purchasing genetic information unless:

- health or genetic services are offered by the employer as part of a bona fide wellness program;
- the employee provides prior, knowing, voluntary, and written authorization;
- only the employee (or family member if the family member is receiving genetic services) and the licensed health care professional or board certified genetic counselor involved in providing such services receive individually identifiable information concerning the results of such services; and
- any individually identifiable genetic information provided is only available for purposes of such services and shall not be disclosed to the employer except in aggregate terms that do not disclose the identity of specific employees.

Several state legislatures have proposed legislation to provide tax incentives to employers who create and maintain wellness programs for their employees. Legislators in California,⁴⁸

³⁷ H. 997, 185th Gen. Ct., Reg. Sess. (Mass. 2007).

³⁸ S. 565, 115th Gen. Assem., 1st Reg. Sess. (Ind. 2007).

³⁹ H. 1582, 105th Gen. Assem., Reg. Sess. (Tenn. 2007); S. 1048, 105th Gen. Assem., Reg. Sess. (Tenn. 2007).

⁴⁰ H. 1582, 105th Gen. Assem., Reg. Sess. (Tenn. 2007); S. 1048, 105th Gen. Assem., Reg. Sess. (Tenn. 2007).

⁴¹ S. 103, 66th Gen. Assem., 1st Reg. Sess. (Colo. 2007).

⁴² A. 1333, 2007–2007 Leg., Reg. Sess. (N.Y. 2007).

⁴³ *Id.*

⁴⁴ S. 659, 2007 GEN. ASSEM., JAN. SESS. (R.I. 2007).

⁴⁵ H.R. 853, 110th Cong. (2007). Known as the "Wellness and Prevention Act of 2007", the bill is currently under consideration by the House subcommittee on health.

⁴⁶ *Id.*

⁴⁷ See H.R. 493, 110th Cong. (2007); S. 358, 110th Cong. (2007).

⁴⁸ A. 1439, 2007 Leg., Reg. Sess. (Cal. 2007).

⁴⁹ H. 325, 2007 Leg., Reg. Sess. (Fla. 2007); S. 194, 2007 Leg., Reg. Sess. (Fla. 2007).

Florida,⁴⁹ Indiana,⁵⁰ New Jersey,⁵¹ and New York⁵² all have introduced bills that would offer employers tax credits for qualified fitness expenditures. Although the specifics of each bill vary, the following are examples of “qualified fitness expenditures:”

- the costs associated with operating and maintaining a gymnasium, weight training room, aerobics workout space, swimming pool, running track or other site used for competitive sports events or games;
- the cost of equipping or sponsoring an amateur athletic team that engages in “vigorous athletic activity;”
- subsidizing an employee’s membership in a health club;
- fifty percent of the cost of employing an individual or organization to provide information on subjects relating to personal health and hygiene and opportunities for fitness enhancement activities, including stretching, aerobics, yoga, etc; and
- the costs associated with hiring an organization to operate an employee fitness facility, provide fitness equipment or employee fitness instruction at the employer’s workplace.

Arizona has introduced legislation authorizing rewards or incentives for wellness programs that comply with the federal HIPAA provisions.⁵³ Wisconsin has adopted a resolution encouraging employers to offer economic incentives to stimulate adoption of workplace wellness programs and generally promoting healthy lifestyles.⁵⁴ Other states have proposed the creation of task forces to study the various issues associated with employee obesity and employer wellness programs.⁵⁵

Massachusetts recently passed legislation mandating the implementation of a wellness program for all MassHealth⁵⁶ enrollees.⁵⁷ The wellness program will be designed to address smoking cessation, diabetes screening for early detection, teen pregnancy prevention, cancer screening for early detection and stroke education. Enrollees complying with the wellness program

will receive reduced premiums and/or co-pays.⁵⁸

Federal organizations are also responding to the trend towards employer wellness programs. The Occupational Health and Safety Administration (OSHA) recently extended its alliance with The American Heart Association (AHA). Among the organization goals of the alliance are to continue to provide health and wellness information to employers.⁵⁹ The alliance has recently focused on programs designed to help employers prepare for medical emergencies and provide training about the use of automated external defibrillators, CPR, and first aid.

B. Wellness Programs and the Law in 2010 and Beyond

In 2001 the U.S. Department of Health and Human Services published *Healthy Workforce 2010: An Essential Health Promotion Sourcebook for Employers, Large and Small*. The forward thinking report observed that “[w]orksites, where most adults typically spend half or more of their waking hours, have a powerful impact on individual’s health.” Two ambitious goals were established: (a) 75 percent of employers (large and small) were to offer a comprehensive employee health promotion program; and (b) 75 percent of employees would be participating in employer-sponsored health promotion activities. Four reasons were provided: (1) improved productivity; (2) lower health care costs; and (3) enhanced corporate image (associated with wellness); and (4) help the nation achieve its health objectives for 2010. *Healthy People 2010* includes 467 objectives to have been accomplished by the end of the first decade of this century. Without question the scientific and demographic evidence speaks with a single voice “that many of the leading causes of disability and premature death in the United States are potentially avoidable or controllable, including most injuries, many serious acute and chronic conditions, and many forms of heart disease, and some cancers.” When this opportunity for “wellness” is added to the projected doubling of health care costs by 2016 and the coming unprecedented shortage of skilled workers, the massive promotion of health in the workplace is certain.

⁵⁰ H. 1008, 115th Gen. Assem. 1st Reg. Sess. (Ind. 2007). See also H. 1083, 115th Gen. Assem. 1st Reg. Sess. (Ind. 2007) (authorizing tax credits for employers who offer health benefit plans to employees).

⁵¹ A. 990, 212th Leg., 2006 Sess. (N.J. 2007); S. 527, 212th Leg., 2006 Sess. (N.J. 2007).

⁵² S. 2595, 2007–2008 Leg., Reg. Sess. (N.Y. 2007).

⁵³ S. 1098, 48th Leg., 1st Reg. Sess. (Ariz. 2007).

⁵⁴ S.R. 3, 2007 Leg., Reg. Sess. (Wis. 2007).

⁵⁵ A. 4316, 2007–2008 Leg., Reg. Sess. (N.Y. 2007); S. 2433, 2007–2008 Leg., Reg. Sess. (N.Y. 2007); S. 72, 80th Leg., Reg. Sess. (Tex. 2007); S. 556, 80th Leg., Reg. Sess. (Tex. 2007); H.C.R. 4, 115th Gen. Assem. 1st Reg. Sess. (Ind. 2007).

⁵⁶ The MassHealth program provides comprehensive health insurance-or help in paying for private health insurance-to nearly one million Massachusetts children, families, seniors, and people with disabilities.

⁵⁷ 2006 Mass. Act. Ch. 58, available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

⁵⁸ *Id.*

⁵⁹ OSHA and AHA, *Alliance Annual Report*, Jan. 22, 2007, available at http://www.osha.gov/dcspl/alliances/aha/annual_report_2005-2006.html.

Whether the aggressive 2010 targets are achieved is less important than the fact that targets have been identified and government-approved. The economic and social forces supporting this initiative are so substantial that legal roadblocks can do no more than offer temporary delays and minor changes in direction. Smoking is a case study as increasingly aggressive countermeasures are legally sanctioned in the workplace. While it is questionable whether testing for nicotine (a lawful substance) will receive legal approval, employer-sponsored programs prohibiting smoking in the workplace and discouraging smoking in the workforce are already sanctioned. Obesity is now a prime workplace target along with physical inactivity. The role of regulation and law in the coming battle will not be one of stopping the inevitable, but rather protecting the individual from harassment and the unnecessary loss of privacy.

Three touchstones are envisioned shaping law and regulation as the year 2010 approaches. First, increasingly aggressive wellness programs will enter the workplace as long as they provide a substantial and measurable return on investment.⁶⁰ The benefits of employer wellness programs are well documented. One study found the annual per participant savings to be \$613 while private companies have reported returns of as much as \$4.50 in lowered medical expenses for every dollar spent on health programs.⁶¹

Second, aggressive support for such programs will require that implementation occur without avoidable harassment of individuals. As harassment law extends the reach of protected categories and includes an increasing share of “rude and offensive” behavior in the workplace, protections for the dignity of obese and inactive employees will grow. We already see this with case law prohibiting harassment if the impact is greater on one gender.⁶² While it may seem like a contradiction that an employer can maintain a health fitness program targeting obesity while protecting overweight employees from rude or demeaning treatment, this is exactly what the future promises. In a sense this is no more complex than applying the golden rule to wellness. Almost all people want “wellness,” yet few want to be insulted or teased in their efforts to become well.

Third, the wellness initiative will require seeking and then protecting highly personal and confidential information from

employees such as their deepest health secrets. This is the exact information that if attributed to the employer would lead to litigation ranging from disability discrimination to invasion of privacy. The solution will involve the rise of third party health program administrators. Professional organizations that can collect information from employees and release to employers only what is needed for the wellness program. The role of this new industry will be critical in achieving workplace wellness. Some abuses will take place due to an initial lack of professionalism on the part of some of the new entrants into the industry as well as the lack of established procedures. This transition will be temporary as quality improves and government assists in institutionalizing the role of the third party health program administrators.

Littler — Your Eyes and Ears For Future Developments

Employers need to anticipate the future as they balance business needs with compliance challenges and risk. An initial wellness program should be reviewed semi-annually to measure legal compliance and the opportunity for new features as case law, regulations, and statutes develop and change. As wellness programs emerge and mature, Littler will monitor and advise employers on legal developments and provide guidance on best practices. We will continue to watch OSHA initiatives, including those arising from the AHA alliance. Littler also will follow and report on developments under the ADA, ERISA, HIPAA, and the workers’ compensation arena, as well as constitutional and state law implications.

⁶⁰ See, e.g., *Wellness Programs Are Worth Every Dollar You Spend*, St. Louis Bus. J., Mar. 31, 2007.

⁶¹ See, e.g., Gregg M. State, et al., *Quantifiable Impact of the Contract for Health Wellness: Health Behaviors, Health Care Costs, Disability and Workers’ Compensation*, 45 J. OF OCCUPATIONAL & ENVIRON. MED. 109–117 (2003); Morgan O’Rourke & Laura Sullivan, *A Health Return on Employee Investment*, 50:11 RISK MANAGEMENT 34–38 (2003); American Assoc. of Health Plans & Health Ins. Assoc. of Am., *The Cost Savings of Disease Management Programs: Report on a Study of Health Plans* (Nov. 2003); Rachel Christensen, *Employment-Based Health Promotion and Wellness Programs*, 22:7 EBRI NOTES 1–6 (2001); Steven G. Aldana, *Financial Impact of Wellness Programs: A Comprehensive Review of the Literature*, 15:5 AM. J. OF HEALTH PROMOTIONS 296–320 (2001).

⁶² In *EEOC v. National Educ. Ass’n*, 422 F.3d 840 (9th Cir. 2005), the court held that screaming and yelling by men at work may be gender-based discrimination even if there is no sexual context to the behavior.

Appendix

Treas. Reg. § 54.9802-1

Effective: February 12, 2007

Code of Federal Regulations Currentness Title 26. Internal Revenue

Chapter I. Internal Revenue Service, Department of the Treasury

Subchapter D. Miscellaneous Excise Taxes

Part 54. Pension Excise Taxes (Refs & Annos)

§ 54.9802-1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) Health factors.

- (1) The term **health factor** means, in relation to an individual, any of the following health status-related factors:
 - (i) Health status;
 - (ii) Medical condition (including both physical and mental illnesses), as defined in § 54.9801-2;
 - (iii) Claims experience;
 - (iv) Receipt of health care;
 - (v) Medical history;
 - (vi) Genetic information, as defined in § 54.9801-2;
 - (vii) Evidence of insurability; or
 - (viii) Disability.
- (2) Evidence of insurability includes
 - (i) Conditions arising out of acts of domestic violence; and
 - (ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.
- (3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 54.9801-6, a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) Prohibited discrimination in rules for eligibility

(1) In general

- (i) A group health plan may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).
- (ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to
 - (A) Enrollment;
 - (B) The effective date of coverage;
 - (C) Waiting (or affiliation) periods;
 - (D) Late and special enrollment;
 - (E) eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

- (F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;
- (G) Continued eligibility; and
- (H) Terminating coverage (including disenrollment) of any individual under the plan.

- (iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.
- (ii) Conclusion. In this Example 1, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2

- (i) Facts. Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: An indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.
- (ii) Conclusion. In this Example 2, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3

- (i) Facts. Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.
- (ii) Conclusion. In this Example 3, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 4

- (i) Facts. A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual A is an employee of the employer maintaining the plan. A and A's dependents have a history of high health claims. Based on the information about A and A's dependents, the issuer excludes A and A's dependents from the group policy it offers to the employer.
- (ii) Conclusion. See Example 4 in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of A and A's dependents from coverage is a

rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for A and A's dependents through other means, the plan violates this paragraph (b)(1).

(2) Application to benefits

(i) General rule

- (A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.
- (B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under ERISA, the Americans with Disabilities Act, or any other law, whether State or Federal.)
- (C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
- (D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1

- (i) Facts. A group health plan applies a \$500,000 lifetime limit on all benefits to each participant or beneficiary covered under the plan. The limit is not directed at

individual participants or beneficiaries.

- (ii) Conclusion. In this Example 1, the limit does not violate this paragraph (b)(2)(i) because \$500,000 of benefits are available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2

- (i) Facts. A group health plan has a \$2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. Participant B files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a \$10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.
- (ii) Conclusion. The facts of this Example 2 strongly suggest that the plan modification is directed at B based on B's claim. Absent outweighing evidence to the contrary, the plan violates this paragraph (b)(2)(i).

Example 3

- (i) A group health plan applies for a group health policy offered by an issuer. Individual C is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about C's adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that C has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for C for that condition. The exclusionary rider is made effective the first day of the next plan year.
- (ii) Conclusion. See Example 3 in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under this paragraph (b)(2)(i) because benefits for C's condition are available to other individuals in the group of similarly situated individuals that includes C but are not available to C. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates the rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i). If the plan provides coverage through this policy and does not provide equivalent coverage for C through other means, the plan violates this paragraph (b)(2)(i).

Example 4

- (i) Facts. A group health plan has a \$2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 4, the limit does not violate this paragraph (b)(2)(i) because \$2,000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific

disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries. (This example does not address whether the plan provision is permissible under the Americans with Disabilities Act or any other applicable law.)

Example 5

- (i) Facts. A group health plan applies a \$2 million lifetime limit on all benefits. However, the \$2 million lifetime limit is reduced to \$10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.
- (ii) Conclusion. In this Example 5, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

Example 6

- (i) Facts. A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 6, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7

- (i) Facts. Under a group health plan, doctor visits are generally subject to a \$250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 7, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 8

- (i) Facts. An employer sponsors a group health plan that is available to all current employees. Under the plan, the medical care expenses of each employee (and the employee's dependents) are reimbursed up to an annual maximum amount. The maximum reimbursement amount with respect to an employee for a year is \$1500 multiplied by the number of years the employee has participated in the plan, reduced by the total reimbursements for prior years.
- (ii) Conclusion. In this Example 8, the variable annual

limit does not violate this paragraph (b)(2)(i). Although the maximum reimbursement amount for a year varies among employees within the same group of similarly situated individuals based on prior claims experience, employees who have participated in the plan for the same length of time are eligible for the same total benefit over that length of time (and the restriction on the maximum reimbursement amount is not directed at any individual participants or beneficiaries based on any health factor).

(ii) Exception for wellness programs.

A group health plan may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment, or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(iii) Specific rule relating to source-of-injury exclusions

- (A) If a group health plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.
- (B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1

- (i) Facts. A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Because of depression, Individual D attempts suicide. As a result, D sustains injuries and is hospitalized for treatment of the injuries. Under the exclusion, the plan denies D benefits for treatment of the injuries.
- (ii) Conclusion. In this Example 1, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of D's injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2

- (i) Facts. A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant E sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for E's head injury.
- (ii) Conclusion. In this Example 2, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However,

if the plan did not allow E to enroll in the plan (or applied different rules for eligibility to E) because E frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(3) Relationship to § 54.9801-3.

- (i) A preexisting condition exclusion is permitted under this section if it
 - (A) Complies with § 54.9801-3;
 - (B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and
 - (C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
- (ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1

- (i) **Facts.** A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 54.9801-3. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.
- (ii) **Conclusion.** In this Example 1, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with § 54.9801-3 (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2

- (i) **Facts.** A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.
- (ii) **Conclusion.** In this Example 2, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups

(c) Prohibited discrimination in premiums or contributions

(1) In general

- (i) A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.
- (ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) Rules relating to premium rates

(i) Group rating based on health factors not restricted under this section.

Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) List billing based on a health factor prohibited.

However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) Examples.

The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1

- (i) **Facts.** An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F's claims experience.
- (ii) **Conclusion.** See Example 1 in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F's claims experience.

Example 2

- (i) **Facts.** Same facts as Example 1, except that the issuer quotes the employer a higher premium rate for F, because of F's claims experience, than for a similarly situated individual.
- (ii) **Conclusion.** See Example 2 in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for F than for a similarly situated individual, see Example 2 in 29 CFR 2590.702(c)(2) and 45 CFR

146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) Exception for wellness programs.

Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(d) Similarly situated individuals.

The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) Participants.

Subject to paragraph (d)(3) of this section, a plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) Beneficiaries

(i) Subject to paragraph (d)(3) of this section, a plan may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

- (A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;
- (B) Relationship to the participant (for example, as a spouse or as a dependent child);
- (C) Marital status;
- (D) With respect to children of a participant, age or student status; or
- (E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) Discrimination directed at individuals.

Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any

health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) Examples.

The rules of this paragraph (d) are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's usual business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 1, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2

- (i) Facts. Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 2, treating spouses and dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3

- (i) Facts. A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.
- (ii) Conclusion. In this Example 3, the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4

- (i) Facts. An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination

of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

- (ii) Conclusion. In this Example 4, imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5

- (i) Facts. An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee G has a different job title and different responsibilities. After G files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with G's job title receive a different benefit package that includes a lower lifetime dollar limit than in the benefit package made available to the other six employees.
- (ii) Conclusion. Under the facts of this Example 5, changing the coverage classification for G based on the existing employment classification for G is not permitted under this paragraph (d) because the creation of the new coverage classification for G is directed at G based on one or more health factors.

(e) Nonconfinement and actively-at-work provisions

(1) Nonconfinement provisions

(i) General rule.

Under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) Examples.

The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1

- (i) Facts. Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.
- (ii) Conclusion. In this Example 1, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2

- (i) Facts. In previous years, a group health plan has provided coverage through a group health insurance policy offered

by Issuer M. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer N. Under Issuer N's policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

- (ii) Conclusion. See Example 2 in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer N violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because the group health insurance coverage restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer. See Example 2 in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for the additional conclusions that under State law Issuer M may also be responsible for providing benefits to such a dependent; and that in a case in which Issuer N has an obligation under 29 CFR 2590.702(e)(1) or 45 CFR 146.121(e)(1) to provide benefits and Issuer M has an obligation under State law to provide benefits, any State laws designed to prevent more than 100% reimbursement, such as State coordination-of-benefits laws, continue to apply.

(2) Actively-at-work and continuous service provisions

(i) General rule

- (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.
- (B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1

- (i) Facts. Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.
- (ii) Conclusion. In this Example 1, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2

- (i) Facts. Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

- (ii) Conclusion. In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

(ii) Exception for the first day of work

- (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multi-employer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.
- (B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1

- (i) Facts. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual H is scheduled to begin work on August 3. However, H is unable to begin work on that day because of illness. H begins working on August 4, and H's coverage is effective on August 4.
- (ii) Conclusion. In this Example 1, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2

- (i) Facts. Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual J is scheduled to begin work on March 24. However, J is unable to begin work on March 24 because of illness. J begins working on April 7 and J's coverage is effective May 1.
- (ii) Conclusion. In this Example 2, the plan provision does not violate this section. However, as in Example 1, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) Relationship to plan provisions defining similarly situated individuals

- (i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other Federal

or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

- (ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1

- (i) Facts. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.
- (ii) Conclusion. In this Example 1, the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2

- (i) Facts. To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.
- (ii) Conclusion. In this Example 2, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3

- (i) Facts. Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee B has been covered under the plan. B experiences a disabling illness that prevents B from working. B takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, B terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation.)
- (ii) Conclusion. In this Example 3, the plan provision terminating B's coverage upon B's termination of employment does not violate this section.

Example 4

- (i) **Facts.** Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee C is laid off for three months. When the layoff begins, C's coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)
- (ii) **Conclusion.** In this Example 4, the plan provision terminating C's coverage upon the cessation of C's performance of services does not violate this section.

(f) Wellness programs.

A wellness program is any program designed to promote health or prevent disease. Paragraphs (b)(2)(ii) and (c)(3) of this section provide exceptions to the general prohibitions against discrimination based on a health factor for plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this paragraph (f). If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, paragraph (f)(1) of this section clarifies that the wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of paragraph (f)(2) of this section are met.

(1) Wellness programs not subject to requirements.

If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate this section, if participation in the program is made available to all similarly situated individuals. Thus, for example, the following programs need not satisfy the requirements of paragraph (f)(2) of this section, if participation in the program is made available to all similarly situated individuals:

- (i) A program that reimburses all or part of the cost for memberships in a fitness center.
- (ii) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- (iii) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- (iv) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.
- (v) A program that provides a reward to employees for attending a monthly health education seminar.

(2) Wellness programs subject to requirements.

If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of this paragraph (f)(2) are met.

- (i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any

class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(2), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

- (ii) The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it 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.
- (iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.
- (iv) The reward under the program must be available to all similarly situated individuals.
 - (A) A reward is not available to all similarly situated individuals for a period unless the program allows
 - (1) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and
 - (2) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.
 - (B) A plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.
- (v) (A) The plan must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under paragraph (f)(2)(iv) of this section. However, if plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.
 - (B) The following language, or substantially similar language, can be used to satisfy the requirement of this paragraph (f)(2)(v): "If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward." In addition, other examples of language that would satisfy this requirement are set forth in Examples 3, 4, and 5 of paragraph (f)(3) of this section.

(3) Examples.

The rules of paragraph (f)(2) of this section are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan. The annual premium for employee-only coverage is \$3,600 (of which the employer pays \$2,700 per year and the employee pays \$900 per year). The annual premium for family coverage is \$9,000 (of which the employer pays \$4,500 per year and the employee pays \$4,500 per year). The plan offers a wellness program with an annual premium rebate of \$360. The program is available only to employees.
- (ii) Conclusion. In this Example 1, the program satisfies the requirements of paragraph (f)(2)(i) of this section because the reward for the wellness program, \$360, does not exceed 20 percent of the total annual cost of employee-only coverage, \$720. ($\$3,600 \times 20\% = \720 .) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20 percent of the cost of family coverage, \$1,800. ($\$9,000 \times 20\% = \$1,800$.)

Example 2

- (i) Facts. A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.
- (ii) Conclusion. In this Example 2, the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. (In addition, plan materials describing the program are required to disclose the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) for obtaining the premium discount. Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

Example 3

- (i) Facts. Same facts as Example 2, except that the plan provides that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count) within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200, or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount." Individual D begins a diet and exercise program but is unable to achieve a cholesterol count under 200 within the prescribed period. D's doctor determines D requires prescription medication to achieve a medically advisable cholesterol count. In addition, the doctor determines that D must be monitored through periodic blood tests to continually reevaluate D's health status. The plan accommodates D by making the discount available to D, but only if D follows the advice of D's doctor's regarding medication and blood tests.

- (ii) Conclusion. In this Example 3, the program is a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

Example 4

- (i) Facts. A group health plan will waive the \$250 annual deductible (which is less than 20 percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard) during the year is given the same discount if the individual satisfies an alternative standard that is reasonable in the burden it imposes and is reasonable taking into consideration the individual's medical situation. All plan materials describing the terms of the wellness program include the following statement: "If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived." Due to a medical condition, Individual E is unable to achieve a BMI of between 19 and 26 and is also unable to follow the walking program. E proposes a program based on the recommendations of E's physician. The plan agrees to make the discount available to E if E follows the physician's recommendations.
- (ii) Conclusion. In this Example 4, the program satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to walk by providing an alternative standard that is reasonable for the individual. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

Example 5

- (i) Facts. In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is 20 percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: “If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge.” It is unreasonably difficult for Individual F to stop smoking cigarettes due to an addiction to nicotine (a medical condition). The plan accommodates F by requiring F to participate in a smoking cessation program to avoid the surcharge. F can avoid the surcharge for as long as F participates in the program, regardless of whether F stops smoking (as long as F continues to be addicted to nicotine).
- (ii) Conclusion. In this Example 5, the premium surcharge is permissible as a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

Example 6

- (i) Facts. Same facts as Example 5, except the plan accommodates F by requiring F to view, over a period of 12 months, a 12-hour video series on health problems associated with tobacco use. F can avoid the surcharge by complying with this requirement.
- (ii) Conclusion. In this Example 6, the requirement to watch the series of video tapes is a reasonable alternative method for avoiding the surcharge.

(g) More favorable treatment of individuals with adverse health factors permitted

(1) In rules for eligibility

- (i) Nothing in this section prevents a group health plan from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)
- (ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1

- (i) Facts. An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 23. However, dependent children who are disabled are eligible for coverage beyond

age 23.

- (ii) Conclusion. In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2

- (i) Facts. An employer sponsors a group health plan, which is generally available to employees (and members of the employee’s family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees \$50 per month for employee-only coverage and \$125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee \$100 per month for employee-only coverage and \$250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee’s family) may have for COBRA continuation coverage.)
- (ii) Conclusion. In this Example 2, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3

- (i) Facts. To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual’s family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual’s COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.
- (ii) Conclusion. In this Example 3, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) In premiums or contributions

- (i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health

factor, such as disability.

- (ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example

- (i) **Facts.** Under a group health plan, employees are generally required to pay \$50 per month for employee-only coverage and \$125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.
- (ii) **Conclusion.** In this Example, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) No effect on other laws.

Compliance with this section is not determinative of compliance with any provision of ERISA (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other Federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) Applicability dates.

This section applies for plan years beginning on or after July 1, 2007.

[T.D. 8931, 66 FR 1396, Jan. 8, 2001; 66 FR 14077, March 9, 2001; T.D. 9298, 71 FR 75030, Dec. 13, 2006; 72 FR 7929, Feb. 22, 2007]

26 C. F. R. § 54.9802-1, 26 CFR § 54.9802-1

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Littler Mendelson Offices

Atlanta, GA
404.233.0330

Boston, MA
617.378.6000

Charlotte, NC
704.972.7000

Chicago, IL
312.372.5520

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Newark, NJ
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New York, NY
212.583.9600

Northwest Arkansas
479.442.5134

Philadelphia, PA
267.402.3000

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Phoenix, AZ
Littler Mendelson Global Migration
Law Group
602.256.6700

Pittsburgh, PA
412.201.7600

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916.830.7200

San Diego, CA
619.232.0441

San Francisco, CA
415.433.1940

San Jose, CA
408.998.4150

Santa Maria, CA
805.934.5770

Seattle, WA
206.623.3300

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209.472.7944

Tysons Corner, VA
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Washington, D.C.
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