national partnership for women & families
Because actions speak louder than words.

June 19, 2015

Ms. Bernadette B. Wilson, Acting Executive Officer

Executive Secretariat
U.S. Equal Employment Opportunity Commission
131 M Street NE
Washington, DC 20507

RE: RIN 3046-AB01, Amendments to Regulations Under the Americans with Disabilities Act

Dear Ms. Wilson:

The National Partnership for Women & Families appreciates the opportunity to submit comments on the Equal Employment Opportunity Commission's (EEOC's) proposed rule, "Amendments to Regulations Under the Americans with Disabilities Act." The proposed rule provides that companies may offer employees "incentives" in the form of rewards or penalties of up to 30 percent of the cost of employee-only health insurance coverage in exchange for employees' participation in workplace wellness programs, including wellness programs that involve medical examinations or questions about employees' health. We urge the EEOC to maintain strong civil rights protections for all workers and are concerned that the proposed regulations as written could instead diminish employees' rights under the Americans with Disabilities Act (ADA) by penalizing employees who decline to participate in workplace wellness programs.

The National Partnership is a non-profit, nonpartisan advocacy organization with more than 40 years of experience promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. Since our creation as the Women's Legal Defense Fund in 1971, we have fought for every significant advance for equal opportunity in the workplace, and we continue to advocate for meaningful safeguards that prevent discrimination against women and families.

The EEOC has proposed this new rule on workplace wellness programs and the ADA because the Commission believes it has a responsibility to interpret the ADA in a manner that also reflects the goals of the Patient Protection and Affordable Care Act (ACA). Although the ACA permits employers to implement wellness programs, it also sets important nondiscrimination standards for such programs that are intended to safeguard civil rights. Section 1557 of the ACA prohibits discrimination on the basis of sex, race, color, national origin and disability by health programs receiving federal funds or by any entity established under Title I of the Act.[1] Section 1557 incorporates and applies numerous civil rights laws, including the ADA. Regulations implementing the ACA specifically state that wellness programs must abide by all other applicable laws, *including the ADA and civil*

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rights laws, and that a program's compliance with the ACA does not create automatic compliance with other laws. Therefore, a truly voluntary wellness program must comply with both the ADA and the ACA.

Under the ADA, employers unlawfully discriminate on the basis of disability if, among other things, they ask their employees medical questions or require employees to take medical exams unless the questions or exams are "job-related and consistent with business necessity." The ADA makes a narrow exception for inquiries and exams that are part of *voluntary* wellness programs. Workplace wellness programs often ask employees to answer "health risk assessments" about their health and behaviors or to undergo "biometric screenings" such as body mass index measurements and blood tests. The EEOC has interpreted "voluntary," with regard to wellness programs, as allowing employers to make medical inquiries or conduct medical exams, but they cannot *require* employees to participate in wellness programs nor can they *penalize* employees for not participating.

Contrary to the plain language of the ADA and the EEOC's Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act, the Commission now proposes to allow employers to offer substantial financial "incentives," of up to 30 percent of the cost of employee-only health insurance coverage, whether in the form of a reward or penalty, to employees who participate in wellness programs that include disability-related inquiries or medical examinations. In other words, the proposed rule allows employers to charge employees who decline to provide their medical information to their employers a penalty of up to 30 percent of the total cost of employee-only coverage. These penalties can be in the form of higher employee premiums, higher deductibles, higher copays or other health expenses, any of which can be very expensive for employees. The average cost of an employee-only PPO plan in 2014 was $6,217, with the employee paying $1,134 of that cost.[2] A 30 percent penalty of $1,865 would more than double what the employee pays.

These penalties will be financially coercive for workers who feel they cannot afford the penalty for refusing to participate. Women and people of color may be particularly adversely affected by the new rule and the coercion that may attend it because they are more likely to experience significant health disparities and are particularly vulnerable to chronic illnesses and disabilities.

For example, women are more likely than men to have medical conditions such as obesity[3] and arthritis.[4] Racial minorities are more likely to face heart disease,[5] obesity[6] or diabetes.[7] More than one-third of African-American women over age 45 report fair or poor health and almost 30 percent have diabetes.[8] African-American women also suffer from the greatest obesity rates.[9] African-Americans have the highest mortality rate of any racial and ethnic group for all cancers combined.[10] They are twice as likely to be diagnosed with diabetes compared to non-Hispanic whites,[11] and also 40 percent more likely to have high blood pressure.[12] Hispanic adults are 1.7 times more likely than non-Hispanic white adults to have been diagnosed with diabetes,[13] and twice as likely to have certain types of cancer compared to non-Hispanic white Americans.[14] Even when income, health insurance and access to care are accounted for, disparities remain.[15] Workers from these population groups with such conditions may have good reasons not to answer questions associated with wellness programs that reveal sensitive health information. Penalties should not coerce these workers into doing so.

In addition, women of childbearing age may face additional challenges that are not addressed by the proposed rule. Health risk assessments may ask women if they are pregnant, about their pregnancy-related medical conditions or limitations, or if they are planning to become pregnant. The EEOC Enforcement Guidance on Pregnancy Discrimination and Related Issues advises companies not to ask employees about pregnancy status or plans to start a family. The proposed regulations should make clear that wellness programs cannot be used to ask women about their pregnancy plans, pregnancy-related medical conditions or limitations, or to discriminate against pregnant women.

The EEOC has proposed this rule because the Commission believes it has to interpret the ADA in accordance with the goals of the ACA. Yet regulations implementing the ACA state that wellness programs must comply with other applicable laws, *including the ADA*, and that compliance with the ACA does not create automatic compliance with other laws. Wellness programs must comply with both the ADA and the ACA, and therefore we urge the agency to revise this rule to ensure that participation in workplace wellness programs remains voluntary. The EEOC has a good model to follow as it considers its final rule. Under the Genetic Information Nondiscrimination Act (GINA), a law that similarly bans employers from requiring or penalizing employees for refusing to provide information about their family medical history, the EEOC took a firm stance against allowing penalties or "rewards" to coerce employees into providing medical information to their employers involuntarily. We urge the EEOC to reconsider its proposed rule and put forth a final rule that reflects the approach taken in implementing GINA.

Thank you for considering our comments. Should you have questions, please reach out to Sarah Fleisch Fink, Senior Policy Counsel, at sflesichfink@nationalpartnership.org or (202) 986-2600.

Sincerely,

National Partnership for Women & Families

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1 42 U.S.C. § 18116.

2 Kaiser Family Foundation. (2014, September 10), *Employer Health Benefits: 2014 Annual Survey* (Exhibit B, p. 2). Retrieved 19 June 2015, from http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report

3 Cynthia L. Ogden et al. (2007, November). *Obesity Among Adults in the United States – No Statistically Significant Change Since 2003-2004* (p. 1)., National Center for Health Statistics. Retrieved 19 June 2015, from http://www.cdc.gov/nchs/data/databriefs/db01.pdf

4 Centers for Disease Control and Prevention. (2013, November 8). *Morbidity and Mortality Weekly Report: Prevalence of Doctor Diagnosed Arthritis and Arthritis-Attributable Activity Limitation – United States, 2010-2012*. Retrieved 19 June 2015, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6244a1.htm

5 Centers for Disease Control and Prevention. (2007, February 16). *Morbidity and Mortality Weekly Report: Prevalence of Heart Disease – United States, 2005* (Table 1). Retrieved 19 June 2015, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5606a2.htm

6 Centers for Disease Control and Prevention. (2009, July 17). *Morbidity and Mortality Weekly Report: Differences in Prevalence of Obesity Among Black, White, and Hispanic Adults – United States, 2006-2008.* Retrieved 19 June 2015, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5827a2.htm

7 Centers for Disease Control and Prevention. (2015, June 2). *Age-Adjusted Incidence of Diagnosed Diabetes per 1,000 Population Aged 18-79 Years, by Race/Ethnicity, United States, 1997-2013*. Retrieved 19 June 2015, from http://www.cdc.gov/diabetes/statistics/incidence/fig6.htm

8 Alina Salganicoff, et al. (2005, July). *Women and Health Care: A National Profile*. Kaiser Family Foundation. Retrieved 19 June 2015, from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey.pdf

9 Ibid.

10 U.S. Department of Health & Human Services, Office of Minority Health. (2013, September 13). *Cancer and African Americans.* Retrieved 19 June 2015, from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=16

11 U.S. Department of Health & Human Services, Office of Minority Health. (2015, June 16). *Diabetes and African Americans*. Retrieved 19 June 2015, from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=18

12 U.S. Department of Health & Human Services, Office of Minority Health. (2015, June 12). *Heart Disease and African Americans*. Retrieved 19 June 2015, from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19

13 U.S. Department of Health & Human Services, Office of Minority Health. (2015, June 15). *Diabetes and Hispanic Americans*. Retrieved 19 June 2015, from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63

14 U.S. Department of Health & Human Services, Office of Minority Health. (2014, June 13). *Cancer and Hispanic Americans*. Retrieved 19 June 2015, from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=61

15 Centers for Disease Control & Prevention. (2013, November 22). *CDC Health Disparities and Inequalities Report – United States, 2013* (pp. 3-5). Retrieved 19 June 2015, from http://www.cdc.gov/mmwr/pdf/other/su6203.pdf