

JCEB Equal Employment Opportunity Commission Questions

May 19, 2005

The following notes are based upon the personal comments of the various individuals on the staff of the Equal Employment Opportunity Commission who attended a meeting with the representatives of the various sections comprising the Joint Committee on Employee Benefits from the American Bar Association on May 19, 2005. The comments were made by these individuals in their individual capacity and not as representatives of the Equal Employment Opportunity Commission. The comments do not represent the position of the Equal Employment Opportunity Commission or of any other government agency or office. None of the comments should be considered official guidance or the position of any agency.

This document has been prepared by private sector members of the American Bar Association's Joint Committee on Employee Benefits who were present at the meeting and reflects their description of the answers to the questions that were discussed at the meeting. This document has not been reviewed or cleared by the government individuals involved in the meeting.

1. What does EEOC see as the implications of *Smith vs. City of Jackson* for employee benefit plans? For instance, does EEOC think it is discriminatory to treat employees who have retired and who are continuing to receive retirement benefits differently from other employees for benefit-plan purposes, either health or retirement?

ANSWER: EEOC is looking at the implications of the decision but has not yet drawn any conclusions. Any anticipated guidance as a result of *Smith* will be developed as needed. No regulatory project is in process at this time.

2. If EEOC cannot issue the retiree-health exemption from ADEA, pursuant to the *AARP* litigation, does EEOC think employers that continue to provide different health coverage to the two different groups of retirees are legally vulnerable? What would an employer have to do to demonstrate that the value of health coverage for the 65+ group, taking Medicare into account, is at least equal to the coverage the employer makes available to the younger retiree group? Could EEOC issue some guidance simplifying that task, which might not be conclusive in court but would at least be influential?

ANSWER: The EEOC staff noted that technically employers are vulnerable in the Third Circuit. They noted that the proposed exemption was their attempt at simplifying the task.

3. Is EEOC aware of any current litigation in the benefits area under the *Smith* rationale? Do they know of any other litigation challenging differentials in health coverage under *Erie County*?

ANSWER: No. They also noted that since the ultimate outcome for the plaintiff's in Erie County was negative there seemed to be little incentive for plaintiff's to pursue such an action. The Staff noted that it is not uncommon for plaintiff's to plead both disparate impact and treatment and that arguably, any case involving treatment would implicate impact.

4. Has EEOC received any additional charges regarding hybrid (cash balance or pension equity type defined benefit) plans? How many unresolved charges are pending with EEOC regarding hybrid plans?

ANSWER: The staff said two new charges had been filed in the last year and that both related to the same employer. There are a total of 571 charges pending.

5. Last year, the EEOC staff noted that since *General Dynamics Land Systems, Inc. v. Cline* (employers are not prohibited from favoring older workers over younger workers) directly conflicts with existing regulations that EEOC would likely move toward eliminating the existing regulations. What has happened since?

ANSWER: They are still working on regulations.

6. The Americans With Disabilities Act, 42 U.S.C. Section 12112(d)(4), prohibits a covered entity from requiring a medical examination, or making inquiries of an employee as to whether he or she has a disability. A covered entity may, however, conduct voluntary medical examinations or disability-related inquiries that are part of an employee health program. In addition, 42 U.S.C. Section 12201(c)(1)-(3) generally exempts from the ADA prohibitions, including the prohibition against requiring a medical examination or disability related inquire, insurance company and HMO activities relating to "underwriting risks, classifying risks, or administering such risks" based on or not inconsistent with state law. That subsection further exempts covered entities from establishing; sponsoring or administering such bona fide health plans (including self-insured plans). See also 29 C.F.R. Section 1630.16(f). HMO X is developing a new product in the employer group market that will contain a number of features designed to encourage wellness. The product will be offered on an insured and self-insured basis. For insured arrangements, the product will be experience-rated for large groups (partially experience-rated for mid-size groups and community rated for small groups.) One of the features of the product will be to request that all employees and dependents who enroll take an annual personal health assessment ("PHA"). The PHA will be detailed, and may constitute a "medical examination" for purposes of 42 U.S.C. Section 12112(d)(4). At a minimum, it will be a disability-related inquiry. If an enrollee chooses to complete the PHA, the enrollee will receive a reward. The reward may include a reduction in the annual deductible applicable to the enrollee (e.g., \$400 instead of \$500), or a reduction in co-payments for certain services. Alternatively, the HMO may reduce the premium it charges the employer in connection with those employees who take

the PHA, which reduction the employer will pass on to the enrollee in the form of a reduced employee premium. Upon completion of the PHA, and an evaluation of the information by the HMO, the enrollee will be invited to participate in one or more applicable wellness arrangements (e.g., smoking cessation, cholesterol reduction, diabetes management programs, etc). Participation in these programs will make enrollees eligible for additional rewards, such as further reduction in deductibles or co-pays. If the enrollee, however, chooses not to take the PHA, then the enrollee will not be eligible to participate in these other programs and obtain the other potential rewards. The total amount of the potential rewards for any enrollee will not exceed 20% of the value of single-employee coverage under the product, and the PHA and wellness programs will constitute bona fide wellness programs under ERISA. See Prop. DOL Regulation Section 1590.702(f). No information provided in the PHA will be shared with the employer. Is the use of a PHA by the HMO in this situation an insurance activity relating to underwriting, classifying, or administering risk, and thus exempt under 42 U.S.C. 12201(c)? Is it also exempt from the ADA by virtue of its being a voluntary medical examination or inquiry that is part of an employee health program? Would the answer be different if the HMO were to **require** every enrollee in the product to take the PHA as a condition of participation?

Proposed Answer: The HMO's use of the PHA -- a medical examination or inquiry for ADA purposes -- is a reasonable tool used to classify and administer experience risk respecting HMO enrollees. The information contained in the PHA will enable the HMO to classify medical risk of the enrollee or dependents, and it will be used to enable the HMO to offer appropriate wellness arrangements that are designed to reduce health risk and the cost of the underwritten program. The HMO believes that there is a reduction in estimated health risk merely when an enrollee takes a PHA, because the information revealed in the PHA will allow the HMO to then direct the enrollee to wellness programs that will further reduce health risk. The reward features are merely an effort by the HMO to pass back to the enrollee a portion of the value of the estimated reduced health risk that the HMO projects for those who take the PHA and participate in the wellness programs. Such a technique is not inconsistent with accepted state practices concerning risk classification and administration, and falls within the 42 U.S.C. Section 12201(c) exemption. Even if the product is designed to require the enrollee to take the PHA, because of the value of PHA information in estimating health risk and its use in directing enrollees into programs to reduce health risk, such a tool would constitute an appropriate risk classification and administration tool, and would fall within the safe harbor of Section 12201(c). As long as the PHA is a voluntary part of the product, it also would constitute a voluntary medical examination or inquiry that is part of an employee health program. The rewards related to taking the PHA, because they would never exceed 20% of the value of single-enrollee coverage, would not constitute a penalty in connection with those who voluntarily choose not to take the PHA. If, however, the PHA were required as a condition of participation in the product, then the PHA would not constitute a voluntary medical examination, or inquiry, although the Section 12201(c) safe harbor would still apply.

ANSWER: The staff said they are not aware of any guidance that would permit what was proposed in the question. They noted they had not issued any informal policy guidance on the issue of whether a substantial

inducement essentially renders the program involuntary. They also noted that ADA's limits on the "collection of data" is applicable for all employees, not just those who are disabled. It was noted that EEOC was receiving more inquiries on data collection issues related to Wellness Plans.