



February 25, 2015

## Five Health Care Developments Important to Employers

Perhaps never before have employers faced so many challenges when it comes to health care issues affecting their workforce. Congress may try to amend the Affordable Care Act (“ACA”). The Supreme Court of the United States is set to decide another case involving the ACA. Telemedicine continues to evolve. The Equal Employment Opportunity Commission (“EEOC”) is challenging wellness programs. Employer-sponsored, on-site health care is on the rise. This issue of Epstein Becker Green’s *Take 5* addresses all of these important health care issues confronting employers:

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### 1. **Potential ACA Changes Impacting Employers Under the New Congress** *By Adam C. Solander & August Emil Huelle*

The ACA has remained, for the most part, intact since its passage nearly five years ago. Despite House Republicans voting to overturn the ACA more than 50 times, repeal efforts stalled in the Democrat-controlled Senate. With the Republicans now in control of both houses of Congress, 2015 promises to be a busy year with regard to ACA legislative efforts. While the Republicans are certain to pass ACA-repealing legislation and amendments, such legislation must survive a veto by President Obama. The following details some of the legislation that has been introduced in the new Congress.

## The Patient CARE Act

On February 5, 2015, U.S. Senator Richard Burr (R-NC), Senate Finance Chairman Orrin Hatch (R-Utah), and House Energy and Commerce Chairman Fred Upton (R-Mich.) [unveiled](#) the Patient Choice, Affordability, Responsibility, and Empowerment (“CARE”) Act. Unlike previous failed attempts to simply repeal the ACA, if signed into law, the Patient CARE Act would repeal the ACA and replace it with new health care reforms, as well as a few current requirements under the ACA.<sup>1</sup>

While the Patient CARE Act is unlikely to survive President Obama’s veto pen, its provisions will likely form the basis of more targeted legislation repealing or amending specific provisions of the ACA.

The Executive Summary of the Patient CARE Act states that all provisions of the ACA are to be repealed under the Patient CARE Act, except for the changes to Medicare. This includes the employer and individual mandates, fees (including annual fees on insurance companies), taxes (including the excise tax on the sale of certain medical devices), and the expansion of Medicaid.

### *Coverage Requirements in the Patient CARE Act*

After repealing the ACA, the Patient CARE Act would reinstate certain ACA provisions with some or no modifications. For example, the ACA prohibits insurance companies and group health plans from imposing lifetime limits on essential health benefits. The Patient CARE Act would prohibit lifetime limits on the dollar value of benefits, although it is not clear whether such limits will apply to essential health benefits only.

The ACA also prohibits insurance companies and group health plans from refusing to renew coverage solely because of the health status of an individual, and it prohibits the retroactive termination of coverage, except in cases of fraud or misrepresentation. The Patient CARE Act would keep these provisions.

Similar to the ACA, the Patient CARE Act proposes to require health plans to offer dependent coverage up to age 26, but the Patient CARE Act would allow any state to opt out of this provision for the plans it regulates.

The ACA prohibits health plans from imposing pre-existing condition exclusions. The Patient CARE Act would also prohibit such exclusions, but only if the individual was continuously enrolled in a health plan for a period of at least 18 months, without a significant break in coverage. Essentially, the proposal’s pre-existing condition provision returns to a pre-ACA era when Health Insurance Portability and Accountability Act (“HIPAA”) standards governed such prohibitions.

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<sup>1</sup> Although legislative language is not yet available, a Patient CARE Act “Executive Summary” sets forth the proposed law.

### *Cost Savings & Tax Credits in the Patient CARE Act*

The Executive Summary states that the policies and reforms set forth under the Patient CARE Act will lower health costs, and it appears that the primary cost savings would result from eliminating the ACA provisions that increase employer costs, such as the employer mandate and various employer fees and taxes. Indeed, the proposal's primary means of generating revenue appears to be shouldered by individual taxpayers through a cap on the tax exclusion for employees' health coverage (at \$12,000 for an individual and \$30,000 for a family). Currently, individuals are permitted an unlimited exclusion from their taxes for employer-provided health coverage. Under the proposal, an employee's health benefit above the threshold would be treated as regular income for that employee, and the provision of health coverage would still be deductible for the employer.

The proposal does provide a targeted tax credit to certain individuals, however, that could be used solely for the purpose of helping to buy health care. Individuals working for a small business with 100 or fewer employees would be eligible to receive the credit. In addition, individuals who do not work at such a small business or a large employer and do not have an offer of health insurance coverage would also be eligible for the credit (to help them buy a plan in the individual market).

Interestingly, the proposal explains that, in the case of individuals who have a health tax credit but who fail to affirmatively choose a plan within a specified timeframe, states would be allowed to randomly assign the individuals to a default health insurance plan. As with many of the proposed provisions, individuals would be able to opt out of the default plan.

### *Additional Provisions in the Patient CARE Act*

Rather than expand Medicaid, as the ACA does, the Patient CARE Act purports to reform Medicaid so that states would adopt a capped allotment, where federal Medicaid dollars would "follow the patient" based on the patient's health status, age, and life circumstances. Moreover, individuals eligible for Medicaid would also be eligible for and have the choice to use the health tax credit to help purchase health coverage.

The Patient CARE Act would also permit individuals to use funds in their flexible spending accounts ("FSAs"), health savings accounts ("HSAs"), health reimbursement arrangements ("HRAs"), and Archer medical savings accounts ("MSAs") to purchase over-the-counter medications. In addition, HSAs would be further enhanced by allowing HSA funds to be used for COBRA coverage and HSA-qualified policies, and spouses would be allowed to make catch-up contributions to the same HSA account.

### **Other Potential Changes**

While the Patient CARE Act is the only alternative offered to the ACA, it is unlikely that it will be signed into law in its entirety. If it is not made law, potential changes to the ACA may primarily come in the form of piecemeal repeals. Since the Republican Party

gained control of the House and Senate, a flurry of new legislation has been introduced to repeal various provisions of the ACA.

Bills that aim to undercut the ACA's core ability to expand health care coverage will likely have less of a chance to survive a presidential veto. For example, the Reclaiming Individual Liberty Act (H.R.117, introduced by Representative Scott Garrett (R-NJ-5) on January 6, 2015), which aims to repeal the mandate that individuals purchase health insurance, will almost surely force a veto as the ACA depends on this provision to extend coverage to individuals not otherwise provided coverage by their employer. Along these same lines, the American Job Protection Act (H.R.248, introduced by Representative Charles W. Boustany, Jr. (R-LA-3), on January 9, 2015), seeks to repeal the employer mandate, a provision integral to the ACA's success that requires large employers to offer health insurance to full-time employees or pay a penalty.

Other bills designed to chip away at smaller, less integral provisions of the ACA, however, appear to carry greater potential to change the ACA. For example, on January 13, 2015, Senator Bill Cassidy (R-LA) introduced S.157, which would repeal the medical device tax, and on January 16, 2015, Senator John Barrasso (R-WY) introduced S.183, which would repeal the annual fee on health insurance providers.

Whether any proposed legislation will become law and change the ACA is yet to be seen, but it is clear that the current health reform landscape is susceptible to change. Savvy employers should not only keep their eyes peeled for these potential changes but also confer with legal counsel to develop a strategy to quickly and effectively respond to the changes when they occur.

## **2. Pending Supreme Court Cases Involving the Affordable Care Act**

*By Stuart M. Gerson*

Although the ACA has been among the preeminent issues of national debate since its passage in 2010, and although its complicated structure, sheer length, and unprecedented nature have led to a host of disputes, the Supreme Court of the United States, despite repeated invitations to do so, has not gone out of its way to resolve many such issues.

This is unsurprising, given the fact that the Supreme Court only will accept cases (and then not all of them) where there is a split in the Circuits or an important issue of federal law has been presented. And this trend generally has held in the ACA context, although some would argue, without apparent evidence, that the conservatives on the Court have gone out of their way to take the one ACA case currently pending argument before the Court.

In any event, since early 2012, the Court has taken three ACA-related cases, and each has been significant. In 2012, the Court decided the fundamental challenge to the constitutionality of the ACA's "individual mandate" provision. The Court held, in a case led by Chief Justice Roberts and the four liberals on the Court, that even though the mandate cannot be authorized under the Commerce Clause, it could be upheld under

the Taxing Clause of the Constitution. *National Federation of Independent Business v. Sibelius*, 132 S.Ct. 2566 (2012).

Next, on the last day of the 2013-2014 term, another sharply divided court decided *Burwell v. Hobby Lobby Stores, Inc.*, \_\_\_ S. Ct. \_\_\_ (2014), holding that the Religious Freedom Restoration Act of 1993 (“RFRA”), which prohibits the “Government [from] substantially burden[ing] a person’s exercise of religion,” prevented the application to closely held (non-public) corporations of the ACA provision requiring that employers offer birth control coverage to their employees. The Court ruled that closely held for-profit corporations are entitled to religious freedom protections and, in contravention of RFRA, the government did not demonstrate that the mandate was the least restrictive means of furthering a compelling government interest. Although controversially recognizing a closely held corporation’s right to free exercise, the case has not spawned a host of successful challenges to the ACA, civil rights laws, and other statutes as some critics feared.

This term, indeed on March 4, 2015, the Court will hear argument in *King v. Burwell*, No. 14-114, a case that touches upon a central mechanism of the ACA: tax credit subsidies payable to economically eligible citizens. This feature of the ACA works hand in hand with the individual mandate upheld in *NFIB v. Sibelius* to allow lower-income persons to purchase health insurance and to assure that insurance pools contain healthier, younger people to offset adverse selection that might drive up insurance costs. At the time the Court granted certiorari, there was no split in the Circuits with respect to the issue presented, although, in a subsequently vacated decision, the D.C. Circuit had disagreed with the Fourth Circuit’s approval of the Internal Revenue Service (“IRS”) regulation in *King*.

Section 36B of the Internal Revenue Code, which was enacted as part of the ACA, authorizes federal tax credit subsidies for health insurance coverage that is purchased through an “Exchange established by the State under section 1311” of the ACA. The question presented in *King* is whether the IRS may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through exchanges established by the federal government under Section 1321 of the ACA. This is a classic case that will pit judicial conservatives who believe in a plain-meaning review of text against judicial liberals who argue that the Court should not focus on a single provision, however literal its terms, that is at odds with the overall legislative scheme.

As even casual observers of the ACA understand, Congress provided for the establishment of insurance exchanges to be marketplaces for health insurance in the states. The ACA provided for the establishment of exchanges by the states themselves but, where states refused to do so (and most did), the federal government could, and did, step in to establish state-based exchanges on its own.

The supporters of *King* argue that the Court need go no further than the literal terms of the provision: in other words, “States” means “States.” And, in the face of the argument that to rely on that view would gut the entire ACA program, these conservatives reply that Congress could have done otherwise but, instead, used the subsidy provision as a

“carrot” to get the states to opt in. The failure of that option lies at the feet of Congress, and it is not for the Court to rewrite the statute.

Faced with the clear language of Section 36B, the government’s response is often quite tortured but, putting aside the immense amount of handwringing and overstatement in the Solicitor General’s brief to the Court, there are two essential, and potentially attractive, features of the government’s argument. The first is that the tax credit subsidies are a necessary component to make the ACA work and to eliminate them would then keep many people from being able to purchase health insurance and would result in a disparate number of unhealthy, and therefore more expensive, people in the insurance pool. This is demonstrably correct, but does it justify the Court’s fixing the statute?

The second pillar of the government’s argument is that, taken as a whole, all of the provisions of the ACA demonstrate that Congress intended that the subsidies at issue would be available to the citizens of every state, whoever was the author of the exchange there. Thus, for example, the Court might look to 26 U.S.C. 36B(a), in which Congress provided that a premium tax credit “shall be allowed” to any “applicable taxpayer.” That term is defined as a taxpayer whose household income is between 100 percent and 400 percent of the federal poverty level. 26 U.S.C. 36B(c)(1)(A). Thus, says the government, not without force, Section 36B(a) defines all income-eligible taxpayers as potentially eligible to receive a credit— regardless of their state of residence or whether that state has elected to operate its own exchange.

Many Court observers believe that there is little question that the three most consistently conservative Justices—Scalia, Thomas, and Alito—will accept the literal argument and strike down the regulation. These observers also believe that the four most liberal Justices—Ginsberg, Breyer, Sotomayor, and Kagan—will accept the government’s “totality” argument. Given Chief Justice Roberts’s surprising position in *NFIB* and Justice Kennedy’s general unpredictability, those two justices are going to be the prime points of the competing arguments in a case likely to be decided just as the Court is closing for business in June.

### **3. Telemedicine and Employers: The New Frontier**

*By René Y. Quashie and Amy F. Lerman*

Telemedicine, the remote diagnosis and treatment of patients using electronic communications, has gone mainstream, and employers are paying attention. The numbers speak for themselves. A [recent Towers Watson study](#) focusing on employers with at least 1,000 employees concluded that U.S. employers could save up to \$6 billion per year if their employees routinely engaged in remote consults for appropriate medical problems instead of visiting emergency rooms, urgent care centers, and physicians’ offices.

Attitudes towards telemedicine more generally in the United States also have undergone a significant shift:

- 30 percent of patients already use computers or mobile devices to check for medical or diagnostic information;
- 74 percent of consumers would use telehealth<sup>2</sup> services if given the opportunity;
- 76 percent of patients prioritize access to care over the need for human interactions with health care providers; and
- 70 percent of patients are comfortable communicating with their health care providers via text, e-mail, or video, in lieu of seeing them in person.

Just as significantly, telemedicine is increasingly viewed as an efficient and cost-effective care delivery vehicle, due to several factors:

- a health care system transitioning from fee-for-service to one where reimbursement is closely tied to quality and patient outcomes;
- an increase in the use of integrated delivery models such as accountable care organizations and medical homes; and
- the relative ubiquity of sophisticated health care technologies.

Indeed, according to a recent *Forbes* magazine article, utilization of telehealth services will increase from 250,000 patients in 2013 to an estimated three million patients in 2018.

Employers, in particular, are paying close attention to developments in telemedicine for another reason: the looming “Cadillac Tax.” Starting in 2018, a 40 percent excise tax will be imposed annually on health plans with premiums exceeding \$10,200 annually for individuals and \$27,500 annually for families. Given this impending tax, employers are looking for efficient ways to cut their employee health care costs. Telemedicine has become an extremely viable option for several reasons:

- Many employees hesitate to take time off work and to pay the copayments associated with physicians’ visits, particularly for ailments perceived as minor.
- Many employees forego physician visits entirely, causing relatively minor health issues to sometimes escalate into costly conditions.

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<sup>2</sup> “Telehealth” is the delivery of health-related care, services, education, and information via telecommunications technology, which includes videoconferencing, remote monitoring, electronic consults, and wireless communications. Telehealth has a broader application than telemedicine and covers both actual clinical services and non-clinical services (such as education, patient management, etc.).

- Although some employers have established onsite clinics where employees can receive sick care and preventive care services, there are high costs associated with creating these clinics.

According to the Towers Watson study, only about 20 percent of U.S. employers offer telemedicine services to employees today, but nearly 40 percent of employers surveyed said that they plan to offer access to such services in 2015, while 33 percent are considering offering access to telemedicine services within the next three years. It is clear to see why. Effective use of telemedicine services could eliminate 15 percent of physician office visits, 15 percent of emergency room visits, and 37 percent of urgent care visits. This all results in significant savings to employers that cover any part of the costs of their employees' health care.

Employers considering the inclusion of telemedicine services in their employee benefit offerings should pay attention to some significant, but not insurmountable, legal and regulatory issues implicated by the use of telemedicine. In brief, those issues include:

- **Licensure:** State licensure laws are a major stumbling block to the interstate practice of telemedicine. With limited exceptions, providers must be licensed in every state in which they intend to practice medicine, and each state has its own licensure requirements. Generally, an out-of-state physician (absent certain exceptions) must obtain a full and unrestricted license to practice medicine on patients in a particular state. This tension creates a patchwork of inconsistent laws.

The Federation of State Medical Boards has developed an Interstate Medical Licensure Compact ("Compact") that would facilitate license portability and the practice of interstate telemedicine. So far, 10 states have introduced bills seeking to become Compact states. There also is a Nurse Licensure Compact in place in 24 states, but it only covers registered nurses and licensed vocational nurses. Compacts for nurse practitioners and physician assistants are being developed.

- **Physician-Patient Relationships:** Among the factors required by states to establish a physician-patient relationship is an evaluation or examination of the patient by the treating physician. This is especially important when the treating physician is prescribing medications for the patient. States have different requirements that must be met in order for a proper examination to have occurred—some require an in-person evaluation or physical examination, while others permit physicians to examine patients using telemedicine technologies.
- **Privacy & Security:** Numerous privacy and security issues are implicated by the use of telemedicine technologies, including compliance with federal and state privacy and security standards, data management, data sharing (and management responsibility for such sharing) with other providers, and data storage.

- **Medical Liability:** Adapting existing principles of medical malpractice liability to telemedicine is a challenging task, especially regarding what constitutes the applicable “standard of care.”
- **Fraud & Abuse:** Telemedicine arrangements must comply with federal and state health care fraud and abuse laws, including anti-kickback statutes and/or physician self-referral prohibitions.

Employers seeking to access the telemedicine market must carefully assess the legal and regulatory requirements, and limitations, of any potential arrangements.

#### **4. Wellness Programs Under EEOC Attack—What to Do Now**

*By Frank C. Morris, Jr.*

##### **Improved Employee Health and Reduced Health Care Costs**

The U.S. Department of Labor has proclaimed that “the Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces.” Employers have embraced wellness programs as a way to improve employee health, enhance productivity, and control health care costs over time.

The extent of that embrace is shown in a 2014 Kaiser Family Foundation & Health Research and Educational Trust annual survey of employer-sponsored health benefits. The survey found that 94 percent of employers with over 200 employees, and 63 percent of smaller employers now sponsor some form of wellness program.

The positive benefits of wellness programs were also discussed at a January 29, 2015, hearing of the Senate Health, Education, Labor, and Pensions (“HELP”) Committee. The opening statements of both the HELP Committee Chair, Senator Lamar Alexander, and the ranking minority member, Senator Patty Murray, emphasized the importance of employer wellness programs as a key to achieving a healthier, more productive work force that can help control health care costs. Such programs are also one of the prime tools being used by employers to help control future health care costs to avoid being subject to the so-called “Cadillac” 40 percent excise tax in January 2018 for “high cost” plans, that is, those costing above \$10,200 for individual coverage and \$27,500 for family coverage, annually.

##### **EEOC Litigation Against Employer Wellness Programs**

Nonetheless, the use of wellness programs designed to motivate employees to improve their health is under scrutiny by the EEOC. EEOC filed three cases in the last five months of 2014, alleging in all three that the employer wellness programs violated the Americans with Disabilities Act (“ADA”). In one of the cases, EEOC also alleged that the wellness program violated the Genetic Information Nondiscrimination Act (“GINA”).

The three cases are *EEOC v. Flambeau, Inc.* (W.D. Wis.), *EEOC v. Orion Energy Systems, Inc.* (E.D. Wis.), and *EEOC v. Honeywell* (D. Minn). In *Flambeau*, EEOC alleges that employees are forced to submit to biometric testing and to complete a health risk assessment (“HRA”) in exchange for Flambeau paying approximately 75 percent of an employee’s health insurance premium. If an employee declined, EEOC alleges that health plan coverage was terminated and he or she could obtain health plan coverage only as a COBRA participant paying 100 percent of the premium.

In *Orion Energy Systems*, EEOC alleges that Orion’s wellness plan required completion of an HRA and limited blood work and disclosure of medical history and that the company paid 100 percent of the health premium for employees who participated in the wellness program but that employees who did not participate had to pay 100 percent of the premium and a \$50 monthly surcharge. EEOC further argues that an employee declined to participate in the wellness program and was then terminated about 30 days later as a result.

In *Honeywell*, EEOC sought a temporary restraining order (“TRO”) and alleged that employees (and covered spouses) had to have biometric testing or face monetary penalties. The Commission claimed that the penalties were a \$500 surcharge if an employee did not complete the tests; a \$1,000 tobacco surcharge if the employee did not complete the tests; a like amount if the employee’s spouse did not complete the tests; and the unavailability of a HSA contribution of up to \$1,500.

Notably, EEOC’s court memorandum did not report some key related facts. These included that the biometric testing was free, that the \$500 surcharge was deducted incrementally over the course of the year, and that the potential HSA contribution actually ranged between \$250 and \$1,500. Also undisclosed was that the one of the two employees filing the underlying charge had previously completed the biometric test and the other was scheduled for the test the day after EEOC filed for the TRO.

EEOC premises its litigation attacks on Title I of the ADA, which bars medical inquiries and exams with two notable exceptions. The first exception is for medical exams that are “job related and consistent with business necessity.” The second exception is for “voluntary medical examinations” if the results are held confidentially consistent with the ADA and are not the basis for discrimination against the employee. The EEOC contends that the testing and assessments are not job-related or consistent with business necessity and that they are not voluntary because of the monetary consequences.

EEOC’s GINA claim in *Honeywell* is that a contribution to an employee’s HSA and the imposition of a tobacco surcharge unlawfully incentivizes using biometric testing and obtaining family medical information from an employee’s spouse. EEOC’s position seems to be that incentives to employees may, if limited, be permissible, but that incentives cannot be in play for medical history about an employee’s spouse. The EEOC fails to articulate how a spouse’s HRA responses are GINA covered, given that a spouse is not genetically related to an employee.

Whether the courts will accept EEOC's position on these issues remains to be seen. It is significant that the District Court in *Honeywell* denied EEOC's TRO request. The court did not, however, address the substance of the case in its order.

### **EEOC's Failure to Provide Guidance on the Interplay of the ADA and Wellness Programs**

What is both curious and troubling is that the EEOC has chosen to litigate against these wellness programs after failing for 14 years to issue regulations as to what is a "voluntary" medical examination and what would make an incentive, whether a benefit or a surcharge, impermissible. EEOC's only "guidance" related to this issue is in its July 2000 Enforcement Guidance. There, EEOC states that a wellness program is voluntary so long as an employer does not require participation or penalize employees who choose not to participate but gave no analysis of what would be improperly requiring participation or penalization.

### **The ACA's Promotion and Enhancement of Wellness Programs**

EEOC's silence became all the more problematic after the passage of the ACA. The ACA's addition to Section 2705(j) of the Public Health Service Act ("PHSA") permits an employer to provide an incentive of up to 30 percent of the cost of employee-only coverage, where employees participate in a standards-based wellness program, and up to 50 percent for a tobacco cessation program. (This is an increase from the 20 percent incentive authorized under HIPPA regulations.) EEOC issued an informal discussion letter in January 2013 wherein it confirmed that it "has not taken a position on whether and to what extent a wellness program reward amounts to a requirement to participate, or whether withholding of the reward from non-participants constitutes a penalty, thus rendering the program involuntary." EEOC's filings in *Honeywell*, *Flambeau*, and *Orion* fail to specify what constitutes "voluntary" participation in a wellness program. Its filings do emphasize a focus on financial penalties for non-participation. The EEOC pleadings argue that the penalties involved are "substantial" or "large" and seek to contrast them with an undefined "mere nominal incentive." The suggestion from the EEOC's court filings is that it assesses what is "voluntary" participation based on the size of a financial penalty or reward.

The EEOC's utter failure to provide guidance on what constitutes a permissible wellness program stands in stark contrast to that of the agencies with a responsibility to enforce and interpret the ACA and other laws that it amended. Detailed guidance on wellness programs has been issued by the U.S. Departments of Health and Human Services, Labor, and the Treasury. Their regulations, consistent with Section 2705(j) of the PHSA, specifically sanction rewards under health contingent wellness programs up to 30 percent of the cost of health insurance and up to 50 percent for programs to prevent or reduce tobacco use. The regulations place no limits on rewards for "participatory" wellness programs, which give rewards without meeting any health status standard,

such as rewards for employees for participating in a hypertension or diabetic management program but without qualifying benchmarks.

EEOC's position in the *Honeywell* case is that a wellness program that complies with the ACA regulations, as was true of Honeywell's carefully crafted plan, still can violate the ADA and GINA.

As a result of the EEOC's wellness program litigations and failure to provide guidance, employers and program providers are confronted with a circumstance where it is essentially impossible to know if a particular health contingent wellness program design might be challenged by the EEOC as violating the ADA. The EEOC-created uncertainty, which has the very real prospect of undercutting the use and success of wellness programs, was decried at the January 29 Senate HELP Committee hearings by both Republican and Democratic senators and essentially all the witnesses.

### **The Eleventh Circuit's Ruling on Wellness Programs**

The ADA's impact on wellness programs was addressed by the U.S. Court of Appeals for the Eleventh Circuit in *Seff v. Broward County*, 691 F.3d 1221 (11th Cir. 2012). In *Seff*, the Court held that a wellness program was set up as a part or term of the employer's insured group health plan and thus fell within the ADA's bona fide benefit plan safe harbor. The effect of this holding is that the wellness program is not subject to EEOC's analysis of whether the incentives do or do not meet the Commission's undefined ADA "voluntary" disclosure standard versus whether they supposedly "compel" an employee to participate. EEOC's *Honeywell* TRO memorandum makes a questionable attempt to argue that the "*Seff* analysis is inconsistent with the language, the legislative history and purposes of the safe harbor provisions." The Court's analysis in *Seff* seems more consistent with the ADA than EEOC's doubtful reading.

### **Will EEOC Guidance Be Forthcoming?**

EEOC's spring 2014 regulatory agenda had advised that it would issue guidance in June 2014 to speak to the extent that the ADA permits employers to offer financial rewards or impose financial penalties in connection with health plans, including wellness programs. EEOC did not do so. EEOC Commissioner Victoria Lipnic, speaking at a client briefing hosted by Epstein Becker Green on October 2, 2014, related that the issue was on the EEOC's agenda but that Commission membership changes would likely delay action.

EEOC's fall 2014 regulatory agenda published on November 21, 2014, states an EEOC intention to issue proposed rules to amend its ADA and GINA regulations to address the "voluntariness" issue in February 2015. Given EEOC's previous delays in issuing regulations, it is certainly possible that this timeline will not be met.

On the other hand, essentially all the senators at the HELP Committee hearing on January 29 strongly counseled EEOC to issue guidance. It was urged at the HELP hearing that the guidance should provide that wellness program compliance with the ACA regulations should also ensure ADA compliance. Until that occurs, however,

employers and wellness plan providers are adrift in a largely uncharted ocean. To the extent the uncertainty delays adoption or refinement of wellness programs, improved employee health opportunities are lost and potential Cadillac tax exposure increases.

### **What Employers and Wellness Program Providers Can Do Now**

Employers that have or are adopting wellness programs should consider the following steps.

First, employers should make sure that their wellness programs meet all requirements of the ACA wellness regulations. This may be very helpful in the event of any EEOC challenge to an employer's program in that it shows compliance with the only available regulations. In addition, EEOC may adopt ACA compliance as an ADA safe harbor, though this is far from certain.

Second, all wellness programs must absolutely assure that individuals with disabilities have alternatives to program requirements or benchmarks for rewards that they cannot meet, or would be medically inadvisable, in light of an individual's disability.

Third, employers should ensure that any information relating to a disability or genetic history obtained in connection with a wellness program is maintained confidentially and never available to employment decision-makers. It also likely makes sense to provide clear and specific notice to employees that any medical/genetic information they disclose will be absolutely off limits to supervisors and managers and will be held confidentially.

Fourth, employers should consider the possible safe harbor provided for under *Seff v. Broward County* for wellness programs that are part of an employer's group health plan. *Seff*, of course, is only a binding precedent in the states of the Eleventh Circuit (Alabama, Florida, and Georgia). Nonetheless, its analysis could well be adopted by other courts that are called upon to address this issue. Designing a wellness program as a component of an employer's health benefit plan is thus certainly worthy of consideration. It is also notable that witnesses at the HELP Committee hearing also urged adoption of the *Seff* analysis either by the EEOC or Congress.

Wellness programs can have great benefits for employees, employers, and the nation—from improved employee health and productivity to controlling health care costs. The EEOC has unnecessarily sown confusion over what wellness programs are permissible under the ADA, notwithstanding ACA compliance. Employers and providers of wellness programs should monitor the EEOC's wellness litigation and potential guidance and proceed carefully but without forsaking these useful programs due to present EEOC-induced uncertainties.

## **5. Employer-Sponsored, On-Site Health Care**

*By Kevin Ryan & Griffin Mulcahey*

It's Monday at 8 a.m. A frantic mom wakes up to discover that her young daughter, Emily, is running a fever with a sore throat. Dad already left for work, and mom needs to be at the office by 9 a.m.

Scenario #1: Mom scrambles, first calling the office of Emily's pediatric physician, but it hasn't opened yet. Next, mom and child drive to an urgent care clinic, where they face at least a two-hour wait. The child is miserable. Mom loses a busy Monday morning at work.

Scenario #2: After realizing that Emily has a fever, mom buckles Emily into the car and drives straight to her employer's office a few minutes away. There, in the on-site clinic at the employer's office, a nurse practitioner is ready and waiting to treat the health care needs of any employee or his/her dependent during business hours. The health care is subsidized by the mother's employer. The nurse immediately examines and treats Emily. Mom drives her daughter home and then returns to her office, just in time for her 9 a.m. meeting.

The first scenario represents the traditional model of health care delivery. Emily's mother has insurance provided by her employer. That insurance reimburses health care providers at the point of care. The employer has no control over the timing or quality of care. The second scenario represents a shift in health care, where employers become more than insurance funders, they organize the delivery of health care services. What's in it for the employer? Proponents argue that employer-sponsored care improves health and wellness for employees, results in reduced absenteeism, and subsequently fosters more consistent day-to-day operations with lower overall health insurance costs. A growing number of companies are pursuing this more holistic approach to employee health and wellness.

### **Employer-Sponsored Offerings at the Workplace**

On-site, employer-sponsored treatment can come in many shapes and sizes with various levels of employer involvement. Employer-sponsored offerings can run a wide range of service levels. The following three tiers of service provide examples of employer-sponsored health care:

1. periodic "health fair" events for flu shots, vaccinations, and as needed primary care treatment;
2. a "health suite," where an employer provides an on-site practitioner, generally a nurse practitioner, who offers primary care in the office at regularly scheduled days and times available for any employee; and
3. at the full-service end of the spectrum, "on-site medical clinics" established by an employer at its office locations offering primary care, flu shots, lab work,

prescription dispensing, or any other needs available to all employees and, sometimes, even their dependents.

### *Health Fairs*

The most basic offering is some form of a “health fair,” which can be as simple as semi-annual or quarterly one-day events for primary care and health risk screenings. Services provided often include flu shots, vaccines, venipuncture (“fingerstick”) blood draws to test for risk factors like cholesterol, and primary care, as needed.

This approach raises several legal risk factors and questions for an employer: Does an employer contract directly with health care providers for their services? If so, what level of care can a health care practitioner provide within his/her scope of practice outside a dedicated clinic? Are there any issues with drawing blood for lab work without proper permits from a state department of health?<sup>3</sup> The employer may consider outsourcing the entire operation to an entity that provides this type of service regularly. This shifts the risk of the process to the third-party entity while still providing the periodic care benefits to patients.

### *Health Suites*

An employer may want to offer something more consistent but without a full physical on-site clinic. This intermediate “health suite” offering provides in-office care for an employer at regular intervals, perhaps once a week or twice a month, without the overhead of an entire medical clinic. Health suite providers may even offer telemedicine services for care on days when the practitioner is not physically present. The health care provided may come from a variety of health care practitioners, such as nurse practitioners, wellness counselors, and nutritionists. On-site care raises many issues for both the employer and the entity that the employer contracts with to provide the services.

The risk factors to consider in regard to this approach include:

- the privacy and security of patient health information, or PHI, accumulated in the office visits (this raises issues under HIPAA and state health information privacy laws);<sup>4</sup>
- access to, and ownership of, medical records during treatment, as in, determining whether the employer or individual health care providers are

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<sup>3</sup> Oregon, as an example, requires a [Health Screen Testing Permit](#) from the Department of Health Services.

<sup>4</sup> HIPAA is the federal Health Insurance Portability Accountability Act, which dictates standards for securing the privacy of patient health information. Some states add additional obligations to the HIPAA standards.

responsible for maintaining patient medical records<sup>5</sup> with a data security system to keep the employee personnel files separate from the employee medical records;

- the scope of services that may be provided by practitioners; potential issues raised by blood samples, lab work,<sup>6</sup> and medical waste; and state regulation of telemedicine services; and
- whether the practitioners can prescribe or even dispense on site.

### *On-Site Medical Clinics*

The most dedicated employer-sponsored offering is a physical on-site medical clinic staffed with nurse practitioners, physician assistants, and medical assistants and, as needed, supervised and/or owned by a licensed physician. An employer-sponsored, on-site clinic may serve one company or a group of companies in close proximity that pools resources to provide services for all employees. Some states regulate this type of full clinic by requiring physician ownership under the “corporate practice of medicine” doctrine, which is enforced to keep corporate interests outside the independent judgment of medical professionals.<sup>7</sup> Or, a state may require the on-site clinic to be licensed by a state department as an outpatient clinic or ambulatory facility.<sup>8</sup> In these instances, the employer may elect to contract with another entity that is familiar with these issues and can manage the day-to-day operations of the practice and develop the proper contractual safeguards to reduce liability.

In addition to the ownership and licensure factors, an on-site clinic must deal with all the overlapping issues discussed in the “health suite” model: practitioner scope, laboratory regulations, HIPAA privacy and medical records controls, and telemedicine regulation, as applicable. An on-site clinic may also want to offer enhanced prescriptive services, including dispensing beyond samples, which raises issues of drug storage and safety, labeling, and potentially federal Drug Enforcement Administration (“DEA”) and state-level reporting requirements.<sup>9</sup>

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<sup>5</sup> Medical record ownership laws vary by state. In California or Pennsylvania, the facility/employer clinic would own the records. Whereas in Texas or Virginia, the individual health care practitioner owns the records.

<sup>6</sup> The federal [Clinical Laboratory Improvements Amendment](#) (“CLIA”) regulates laboratory testing nationally, with many state agencies mandating additional oversight and licensure obligations.

<sup>7</sup> Illinois and California are examples of states that require physician ownership of medical practices, with physician oversight of nurse practitioners and other medical professionals. The employer or a management company can contract with the physician practice to provide services.

<sup>8</sup> Florida and Massachusetts are examples of states where clinic licensure may be required.

<sup>9</sup> Federal DEA regulations dictate storage, security, and recordkeeping requirements for any clinic practice that dispenses controlled substances. All states regulate quantities and schedules of drugs that may be dispensed from a non-pharmacy clinic and obligate dispensing practitioners to report controlled substances in electronic prescription drug monitoring programs.

## Employer-Sponsored Treatment in the Future

Given the legal obstacles, some employers may question whether becoming a proactive provider of care is worth the effort as compared to the traditional insurer reimbursement role. Proponents argue that successful employer-sponsored care not only helps reduce the burden of health needs for working families, but also can provide significant financial gains by helping monitor the more chronic conditions that lead to high absenteeism.

An employee with diabetes or high cholesterol may, at times, either forget to take medication or skip a follow-up appointment that requires leaving work. By offering on-site care, the employee will receive immediate access to follow-up care, and the on-site practitioners can monitor prescription refills and other gains in health and wellness to create long-term improved outcomes and reduce long-term spending on insurance costs.

The next time someone in your household wakes up with a fever and nasty sore throat, will you drive straight to work?

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For additional information about the issues discussed above, please contact the Epstein Becker Green attorney who regularly handles your legal matters or an author of this *Take 5*:

<b>Adam C. Solander</b> Washington, DC 202-861-1884 asolander@ebglaw.com	<b>August Emil Huelle</b> New York 212-351-3715 ahuelle@ebglaw.com	<b>Stuart M. Gerson</b> Washington, DC 202-861-4180 sgerson@ebglaw.com	<b>René Y. Quashie</b> Washington, DC 202-861-1888 rquashie@ebglaw.com
<b>Amy F. Lerman</b> Washington, DC 202-861-1832 alerman@ebglaw.com	<b>Frank C. Morris, Jr.</b> Washington, DC 202-861-1880 fmorris@ebglaw.com	<b>Kevin J. Ryan</b> Chicago 312-499-1421 kryan@ebglaw.com	<b>Griffin W. Mulcahey</b> Chicago 312-499-1440 gmulcahey@ebglaw.com

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