The Labor, Employment and Benefits Law Implications of the Affordable Care Act: Are You Prepared?

May 2013

AUTHORS

Ilyse Schuman
Michael Lotito
Steve Friedman
Barry Hartstein
Linda Jackson
Tammy McCutchen

Littler™

WPI
LITTLER WORKPLACE POLICY INSTITUTE

IMPORTANT NOTICE

This publication is not a do-it-yourself guide to resolving employment disputes or handling employment litigation. Nonetheless, employers involved in ongoing disputes and litigation will find the information extremely useful in understanding the issues raised and their legal context. The Littler Report is not a substitute for experienced legal counsel and does not provide legal advice or attempt to address the numerous factual issues that inevitably arise in any employment-related dispute.

Table of Contents

INTRODUCTION

For millions of employers around the country, the Patient Protection and Affordable Care Act (ACA) represents much more than a collection of new requirements for health plans. The sweeping healthcare reform law potentially changes the landscape of the American workplace and workforce. While the law imposes significant new obligations on employers and group health plans, legal and political uncertainty about the ACA's future may have delayed planning for its full implementation. Now, with the law's key provisions slated to become effective in 2014, employers are viewing the ACA with a renewed sense of urgency.

The ACA has spawned a new lexicon associated with the requirement that, beginning in 2014, employers with 50 or more full-time employees and full-time equivalents must either offer health coverage that meets certain standards or pay a penalty. This "play-or-pay" or "employer mandate" provision joins the terms "individual mandate" and "exchanges" in describing how the health insurance market and the nature of employer-sponsored coverage will change next year. This paper will look beyond the new terminology to provide a fuller picture of what the healthcare reform law and its voluminous regulations mean for employers and the workplace.

While the requirements of the "play-or-pay" penalty itself have received the attention of many employers, how this and other provisions in the ACA could implicate other aspects of employment, labor and benefits law may be overlooked. From wellness programs to whistleblower protections, this paper examines the broader impact of healthcare reform law on workplace policy. This paper builds upon findings from a Gallup Organization survey specifically designed to gauge employer reaction to the ACA. As the Gallup research confirms, employers are struggling with how best to respond to the healthcare reform law for their business. Deciding whether to "play-or-pay" or restructure benefit plans and the workforce are crucial questions facing employers. Those taking a comprehensive, individualized approach to developing the optimal healthcare reform strategy will be better positioned to navigate the challenges and opportunities ahead.

BACKGROUND

The ACA created numerous new requirements for the design and administration of employer health plans. Coupling the mandate that employers offer health care coverage under the play-or-pay provision with the mandate that all individuals obtain insurance coverage fundamentally changes the framework of health care coverage for the vast majority of Americans. The following is a summary of key provisions of the ACA:

Plan Design Changes

- Plans must provide dependent coverage for children up to age 26 (effective in 2011; until 2014, grandfathered plans[1] need not provide coverage to dependents who are eligible for other employer-provided coverage).
- Plans must provide for preventive care without cost-sharing (effective in 2011; non-grandfathered plans only).
- Plans must provide an enhanced internal appeals process and an external independent review stage (effective in 2011; non-grandfathered plans only).
- Plans must not rescind coverage retroactively, except in situations involving fraud (effective in 2011).
- Plans must not impose pre-existing condition exclusions on individuals under the age of 19 (effective in 2011) and for all individuals (effective in 2014).
- Insured plans must not discriminate in favor of highly compensated employees under rules similar to the nondiscrimination rules already applicable to self-insured plans (effective in 2011, but enforcement delayed until regulations are issued; non-grandfathered plans only).
- Plans must not place lifetime limits on essential health benefits (effective in 2011) and may only place annual dollar limits that are at or above specified levels (with no annual limit permitted from and after 2014).

1 Grandfathered plans are exempt from some, but not all of the ACA insurance market reforms. Grandfathered plans are those plans that were in effect on March 23, 2010 and have not made any specified changes that would cause a plan to lose such status. 75 Fed. R. 34538 (June 17, 2010).

- Plans must provide a Summary of Benefits and Coverage upon application, enrollment, and re-enrollment in the plan, and a notice of material modifications describing plan changes must be provided 60 days before modifications are effective (both effective in 2013).
- Flexible spending account contributions by an employee must be limited to $2,500 per year (effective in 2013).
- Plans must not have waiting periods for entry into a plan in excess of 90 days (effective in 2014).
- Employers with more than 200 employees must automatically enroll full-time employees (delayed until regulations are issued—will not be effective by the original 2014 effective date).
- The level of penalties/incentives for wellness plans may be as much as 30% of the cost of coverage—an increase from the current 20%; may rise up to 50% by regulation (effective in 2014).

Individual Mandate

Beginning in 2014, with certain exceptions, all individuals will be required to maintain "minimum essential coverage" in 2014. Individuals who fail to satisfy this requirement will be subject to a penalty that varies depending on their income level—the penalty will be phased in between 2014 and 2016.

Health Insurance Exchanges

The exchanges will begin to operate in 2014 and are virtual marketplaces that allow individuals and eligible employers to purchase health insurance. Prior to 2016, the exchanges will initially be open to employers with up to 100 employees (states can limit to 50 employees). Beginning in 2017, states can open exchanges to larger employers.

Federal Tax Credits and Cost-Sharing Subsidies

Individuals with household incomes between 100% and 400% of the federal poverty level may be eligible for federal premium tax credits or cost-sharing subsidies to purchase insurance through an exchange.

Employer Responsibility—Play-or-Pay Penalty

The penalty applies to "large" employers with 50 or more full-time and full-time equivalent employees. Full-time employees are defined as those that work 30 or more hours a week calculated on a monthly basis (equating to 130 hours a month). Even though the hours of part-time workers are counted for purposes of determining whether an employer is a "large" employer, the penalty only applies with respect to full-time employees. The IRS has issued a proposed rule[2] providing a "look back/stability" safe harbor for purposes of defining a "full-time employee." Under this approach, an employer could determine each employee's full-time status by looking back at a defined period of 3 to 12 months to determine full-time status for a subsequent stability period.

- Employers that fail to provide "minimum essential" health coverage to 95% of their full-time employees (and their children) will pay a penalty equal to $2,000/year for each full-time employee in excess of 30 employees if any full-time employee receives a federal subsidy to purchase insurance through an exchange.
- Employers who offer coverage that does not provide "minimum value" (at least 60% of the actuarial value) or is not affordable (the premium is more than 9.5% of the employee's compensation) will pay the lesser of the above penalty or $3,000 for each full-time employee receiving a premium tax credit to purchase coverage through an exchange.

Cadillac Health Plan Tax

Targeting high-value employer-sponsored health plans, the ACA will impose a 40% excise tax on the annual value of employer-provided health coverage that exceeds $10,200 for single coverage or $27,500 for family coverage beginning in 2018. The value of coverage includes both employer and employee contributions.

2 78 Fed. R. 218 (Jan. 2, 2013).

TRADITIONAL LABOR ISSUES

In the area of traditional labor, the ACA unfortunately raises more questions for employers than it answers and could have just as great of an impact on employers who do not employ union workers as those that do. It is already well-known amongst employers who have experience in negotiating with unions that health benefits are a pivotal issue in any bargaining process. Medical coverage provided under a collective bargaining agreement (CBA) is either sponsored by the employer, *i.e.* "single employer," or sponsored by the union itself. This union-sponsored coverage is typically utilized to cover multiple employers. These multi-employer plans are oftentimes expensive, typically around $12,000 per year for the employee and their family.[3] Unfortunately for both the employers and employees, these costs continue to rise.

One major question impacting employers with a union presence is what to do about health plans offered pursuant to CBAs that do not comply with the ACA. The penalties imposed on employers subject to the ACA who do not provide affordable and "minimum value" coverage can be substantial. Plus, with the law's elimination of cost-saving measures such as lifetime limits on medical and prescription coverage,[4] employers will be under enormous pressure to limit their exposure. In general, the ACA does not recognize the unique challenges presented by CBAs and does not afford special treatment for such arrangements. Without further guidance from federal regulations, it is unclear what, if any, flexibility will be given to employers with respect to ACA compliance in the union bargaining context. As it is, because of previous waivers from the early requirements of ACA, some union plans are already behind in implementation.[5]

Beyond basic compliance, the ACA also brings with it a multitude of strategic uncertainties for employers and even unions. The ACA may end up changing the landscape, eventually causing division of some multi-employer plans.[6] For example, employers who are members of multi-employer plans, especially smaller-sized employers, may determine that it is actually in their best interest to leave the multi-employer plan, drop coverage for their union employees, and pay the tax penalty for failure to provide coverage. So long as they follow the requirements set forth by the National Labor Relations Board to provide notice to other members of the multi-employer plan,[7] and are able to negotiate such terms with the union, they may do so. At a very minimum, the exit of one employer could certainly have a cost-impact on the employers who remain in the plan. The issue could be even more complicated if any employer remaining in the plan tried to take advantage of an existing "most favored nation" clause. Such a clause could allow the other members of the multi-employer plan to drop health and welfare benefits prior to the expiration of their own CBAs. If this were to occur, unions would most likely strike.

The employers who are facing CBA expirations in early 2014 could really be the true trailblazers on these issues if they choose to be. For those employers who find themselves in that position but want to retain flexibility to change course, one option would be to try and enter into shorter term CBAs or include a provision to re-open the benefits issue at a later date once the health insurance exchanges are established.

The unions themselves are struggling with the consequences of the ACA. While unions originally supported the ACA, they are now showing concern that some of the law's requirements will drive up the costs of their multi-employer health care plans, which some have predicted will eventually make the unionized workers less competitive.[8] Indeed, the United Union of Roofers, Waterproofers and Allied Workers International President Kinsey M. Robinson issued a statement on April 16, 2013 calling for the repeal or reform of the ACA.[9] While the ACA provides that a person is entitled to a federal subsidy to help pay for the cost of insurance when that person does not receive employer-sponsored health coverage and has a certain household income,[10] some union leaders are asking for a concession for

3 Janet Adamy & Melanie Trottman, *Some Unions Grow Wary of Health Law They Backed*, WALL ST. JOURNAL, Jan. 30, 2013, at A1.

4 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1001, 124 Stat. 119, 318-319 (2010), amending 42 U.S.C. 300gg-11.

5 Adamy & Trottman, *supra* note 3.

6 As of 2009, there were 1,801 multiemployer health plans. Group Health Plans Report, 2009 data, U.S. Department of Labor, April 2012.

7 *See Retail Assocs., Inc.*, 120 N.L.R.B 388, 395 (1958) (prior to the start of multi-employer bargaining, an employer may unilaterally withdraw by giving the union and the multi-employer association adequate written notice demonstrating an unambiguous intent to withdraw); *see also The Carvel Co.*, 226 N.L.R.B. 111 (1976) (union's oral notice of contract reopening followed by union letter to association president containing union's proposed contract changes constituted beginning of negotiations, even though no bargaining sessions had taken place).

8 Adamy & Trottman, *supra* note 3.

9 *See* http://www.sacbee.com/2013/04/16/5345736/roofers-union-seeks-repealreform.html.

10 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1402, 124 Stat. 119, 318-319 (2010), amending 42 U.S.C. 18071.

lower-paid union employees to be entitled to the federal subsidy, despite the fact that they will continue on the union health insurance plan.[11] The regulators themselves are grappling with how to treat multi-employer plans.[12] Final regulations on the Play-or-Pay penalty may either make such plans more attractive for employers or less.

Yet another issue affecting unionized employers is the possible impact that the ACA could have on the retired workers receiving benefits under CBAs. This is a huge issue for some unions, especially those that have more retired members than active ones. Employers will need to examine if their CBAs contain language guaranteeing retiree coverage in perpetuity or for some other period of time, such as the expiration of the CBA. With access to health insurance coverage available to older Americans through the exchanges, the unions may be more willing to drop or otherwise limit retiree coverage.

On the other side of the coin are employers who are completely union-free. While these employers do not have current CBAs with which to contend, they should be aware that certain elements of the ACA could give unions an opening to organize their employees. For example, if an employer reduces hours to avoid coverage or simply eliminates benefits completely, it is likely going impact recruitment, retention, and employee morale. If the "executives" keep the old plan but the employer eliminates the plan for the hourly workforce, there are sure to be fairness concerns raised. Also, a possible perception could arise that, by elimination or reduction in the health plan, the employer has now benefitted from a cost saving. Employees will most certainly wonder where they money is going to go, and the employee relations impact from eliminating or changing the healthcare plan may outweigh any benefits.

Further, if plan modifications affect the supervisors who will be responsible for promoting the change to their employees, their morale could be affected as well and the employer may not be able to count on the supervisors if they are also feeling a sense of mistreatment. All of these possible risks to morale could in turn have a direct impact on the employees' collective willingness to consider unionizing.

The employees may be more willing to listen to a union offering to bargain with the employer to become a part of a multi-employer plan or single-employer plan. A union drive could have a significant impact on company branding and public relations. Thus, all employers should factor in the possibility of a union drive when making healthcare coverage decisions.

All of the issues listed above will affect employers who are partially unionized. If the union employees keep their healthcare plan but the non-union employees do not, morale issues could be further amplified and the challenges could become more profound. If an employer wants to jettison the health plan for the non-union employees, the employer may want to first analyze the options concerning the healthcare plan for union employees. If the workforce consists of both union and non-union employees, and the union employees are the only ones with healthcare coverage remaining, employers may find that the non-union employees are more open to the idea of organizing in order to get those benefits back. However, if the union members themselves also do not have health benefits, there would be no argument that the union somehow "preserved" benefits. Amidst these questions one thing is clear—the ACA will have a significant, long-term impact on labor relations.

ANTI-RETALIATION AND FLSA ISSUES

In the realm of retaliation, the ACA adds yet another avenue for employees to assert complaints and to possibly obtain damages. Specifically, section 1558 of the ACA amends the Fair Labor Standards Act (FLSA) to protect employees from retaliation for reporting alleged violations of Title I of the ACA, for receiving a health insurance tax credit under section 36B of the Internal Revenue Code, or for receiving a subsidy under section 1402 of the ACA (aka "the affordability assistance provisions").[13] These anti-retaliation provisions apply to a wide range of possible complainants, including employees of both private and public sector employers, as well as former employees and job applicants.[14]

11 Adamy & Trottman, *supra* note 3.

12 78 Fed. R. 218 (Jan. 2, 2013).

13 *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1558, 124 Stat. 119, 318-319 (2010), amending 29 U.S.C. 218c.

14 *See* OSHA Interim Final Rule, Procedures for the Handling of Retaliation Complaints Under Section 1558 of the Affordable Care Act at p 5 (Feb. 22, 2013) (*"OSHA Interim Final Rule"*); *see also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1201, 124 Stat. 119, 318-319 (2010), amending, 42 U.S.C. § 300gg ("The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage."). In 2014, the Act's protection will expand to include retaliation by health insurance issuers offering group or individual health insurance coverage regardless of whether those issuers are the employer of the person retaliated against.

Protection for participation in the affordability assistance programs arose from the concern that employers might retaliate since an employee's participation triggers penalties for certain large employers that do not offer affordable health care to full-time employees. Section 1558 is consistent with the fairly recent trend of additional retaliation and whistleblower protections, enhanced funding for enforcement, and creative incentives (including "bounties") to encourage the reporting of alleged violations of law. OSHA alone now enforces twenty-two federal whistleblower statutes, and sixteen states have passed or strengthened whistleblower laws.[15]

Under this new provision, employees are required to file their complaints of retaliation with OSHA, and they must do so within 180 days of the alleged violation. Complaints may be filed by visiting or calling a local OSHA office, or by sending a written complaint. OSHA will deem the complaint sufficient if, in addition to information obtained by OSHA interviews with the employee, the complaint alleges (1) the employee engaged in protected activity; (2) the respondent knew or suspected that the employee engaged in the protected activity; (3) the employee suffered an adverse action; and (4) circumstances raise the inference that the protected activity was a contributing factor in the adverse action. Inferences may be drawn by the timing of the protected activity vis a vis the adverse action. Notably, however, the complaint will not be investigated (or the investigation will be discontinued if it is underway) if the respondent demonstrates by clear and convincing evidence that it would have taken the same adverse action in the absence of the complainant's protected activity.[16] Remedies include reinstatement, back wages, restoration of benefits, and may also include attorneys' fees and costs.[17] The Respondent may petition for attorney's fees not to exceed $1,000.00 if the finding is that a violation did not occur and the Respondent alleges that the complaint was frivolous or brought in bad faith.[18] Any aggrieved party can seek review of OSHA's decision with the Chief Administrative Law Judge, the Administrative Review Board, and eventually seek a petition for review with the U.S. Court of Appeals.[19]

These new FLSA provisions enacted by the ACA and OSHA's corresponding regulations do nothing to change what would be considered retaliatory employment actions, which could include termination, demotion, denial of overtime, promotion or other benefits, failure to hire or rehire, intimidation, reassignment affecting promotion, discipline, blacklisting, and the reduction of pay or hours. However, even though the adverse actions remain the same, employers should pay close attention to any future retaliation theories. Employers should advise with counsel before taking any creative steps to avoid penalties under the ACA to ensure that there is no retaliatory impact. An action for retaliation may lie if the employee can show that the activity protected by section 1558 of the ACA was a contributing factor in the adverse employment action. It will then be up to the employer to prove that it would have taken the same action in the absence of the protected activity.[20]

One possible area of concern is the affect that the ACA retaliation provision may have on an employer's ability to control the hours worked by employees and their actual hiring. After some employers announced reduction of employee work hours, questions were raised regarding whether the retaliation provision would prohibit an employer from reducing employees work hours to under 30, or reducing employee ranks to under the 50 employee threshold, in order to avoid triggering the ACA penalties. This issue is likely to become fertile grounds for litigation. The Department of Labor or a plaintiffs' attorney may try to allege that terminating employees or reducing an employees work hours below 30 in order to avoid application of the ACA is retaliation against employees who, absent that action, would be eligible for an ACA credit or subsidy. This argument seems a stretch given the language of new Section 18C, itself, which prohibits retaliation against an employee who "received" an ACA credit or subsidy. Further, such a prohibition would be unprecedented and, thus, should not be inferred without unambiguous statutory language. Congress has never before even come close to trying to control the number of employees that businesses must hire. Other federal employment statutes contain provisions limiting coverage based on number of employees while also prohibiting retaliation. Yet, the federal government has never asserted that those non-retaliation provisions prohibit companies from terminating employees. Further, the FLSA has never been interpreted as limiting an employer's discretion in setting work hours. Under the FLSA, an employee can be required to work 20 hours, 30 hours or 60 hours; the law only

15 *See* http://www.whistleblowers.gov/statutes_page.html; *see also*, Gregory Keating, *Retaliation and Whistleblowing: A Guide for Human Resources Professionals and Counsel*, Fourth Edition, Tables 6-1 and 6-2.

16 *See OSHA Interim Final Rule* at p 16; *see also* 29 C.F.R. 1984.104(e).

17 29 C.F.R. 1984.105(a)(1).

18 29 C.F.R. 1984.105(b).

19 29 C.F.R. 1984.106-112.

20 *See OSHA Interim Final Rule* at p 18; *see also* 29 C.F.R. 1984.104(e).

provides that overtime must be paid for hours over 40. Employers have long managed employee hours to under 40 in order to avoid paying overtime. Never has such a practice been questioned as prohibited FLSA retaliation. However, it remains to be seen if such an action to reduce employee hours could also violate the Employee Retirement Income Security Act (ERISA) (*See infra*, Section 5).

As with any adverse action that an employer takes against an employee, it is critical to ensure that it is independent of any protected activity. The employer should also be vigilant and objective in conducting and documenting performance assessments so that adverse actions can be more readily defended. An employer would also be wise to create a culture of compliance and internal reporting as to suspected violations. With the ACA provisions, if a human resources professional has access to knowledge of which employees receive tax credits or subsidies under the ACA, there could be a greater inference of retaliation. This scenario increases the need to ensure that the adverse action is not impacted by that knowledge, and that the employer has what it needs to demonstrate that it would have taken the same adverse action in the absence of the protected activity. Adding reference to the ACA to any written anti-retaliation/whistleblowing policies would also be prudent. And, if an employer is considering making changes to employee work hours or to the number of employees, or otherwise taking an adverse employment action against an employee who is eligible for a federal subsidy, it would be wise to consult with an attorney before doing so. Even frivolous lawsuits are expensive and avoiding lawsuits is always preferable.

BENEFITS ISSUES

In the benefits area, the ACA has caused employers to scrutinize not only the healthcare benefits that they are providing to employees but other benefit plans and programs as well. The ACA dictates that an employer provides health coverage to virtually all full-time employees. The coverage must be "affordable" and meet certain "minimum value" standards, which limit the costs paid by employees. If an employer fails to cover its full-time employees, or to provide affordable, minimum value coverage, the IRS will assess a penalty against the employer.

The U.S. has long relied upon a system in which employers provide benefits to employees on a voluntary basis. However, now that the ACA has imposed mandatory benefits for many employees, one possible consequence of the ACA is that increased costs of compliance will degrade the other benefits that employers had been providing. It is well known that healthcare costs have exploded in recent years and that this trend may continue on account of the benefit mandates and other costs of health care compliance embedded in the ACA. These increased costs may very well force employers to consider plan cutbacks or, unfortunately, even the termination of other benefits offerings.

There is nothing in the ACA that would prohibit an employer from cutting other benefits in order to fund the inordinate costs of providing the mandated health coverage under the ACA. Employers, justifiably concerned about healthcare costs, may feel as though they need to scrutinize every other benefit provided to employees outside the healthcare arena. This may become most evident in the arena of retirement plan offerings as employers analyze the possibility of reducing accruals under retirement plans. Even taking the ACA out of the picture, defined benefit pension plans have become untenable vehicles for many employers due to higher than expected funding obligations in an era with lagging investment performance, low interest rates and laws requiring higher funding levels. Employers have, not unexpectedly, terminated and frozen existing arrangements and in America's burgeoning new industries, such plans are rarely, if ever, being established. These changes are occurring at a time when it is becoming clear that most Americans have insufficient assets to retire at age 65. Unfortunately, the ACA saps even more funds from the benefits pool, prompting employers who had been scaling down offerings to make further cuts.

The ACA may also have a depressive effect on the job market. The ACA requires employers to offer health care coverage to full-time employees if an employer employs at least 50 full-employees and "full time equivalents." The number of full-time equivalent employees is established by counting all part-time monthly hours and dividing this number by 120. While a variety of laws impose requirements on employers whose payroll ranks swell above a certain number, very few impose the massive costs on employers similar to the ACA. An unfortunate consequence of these increased costs may be that small employers implement hiring freezes or slow-downs in order to keep their employee ranks below the ACA coverage threshold. This is certainly is not a desirable by-product of a law, especially one that takes effect in an era of anemic job growth and economic uncertainty.

One strategy that is oft-discussed to reduce ACA costs is workforce restructuring initiatives put in place to maximize the number of employees who would not need to be offered coverage under the ACA. In other words, an employer using this strategy would move to maximize the number of employees working under 30 hours per week (or 130 hours per month). However, as explained below, from a benefits perspective, there are possible legal risks to moving employees from full-time schedules to part-time schedules and to hiring more part-time workers.

ERISA Section 510 provides that "[i]t shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan." This provision has been construed to restrict an employer's right not only to entirely terminate the working relationship between an employer and a plan participant or beneficiary in order to deny him or her benefits, but also to reclassify an employee's status (e.g., from employee to independent contractor) to deny him or her benefits.[21] We are not aware of a court providing an ERISA Section 510 remedy in connection with an employee's change in status from full-time to part-time; however, this is certainly not inconceivable in an era where a principal reason for the change in status is the denial of healthcare benefits. For this reason, there is concern that the prohibitions of ERISA section 510 could restrict an employer's actions to restructure its workforce if individuals who had been benefits eligible or who would be benefits eligible in 2014 under the current terms of the plan, were made ineligible in 2014 or later so that benefit costs could be reduced. Complicating this issue is a Supreme Court decision that held conduct that appears discriminatory may be insulated from liability under ERISA section 510 if it could be demonstrated that the defendant acted in furtherance of a "fundamental business decision."[22]

Adding further uncertainty to this issue, courts have consistently required ERISA section 510 claimants to first and foremost be eligible for benefits.[23] Therefore, in the case where an employer reduces a full-time employee's hours to avoid a penalty in 2014, but that employee was not eligible for benefits prior to 2014, that employee may not have a path to an ERISA section 510 claim. In this case, it would be feasible to claim that the employer did nothing to discriminate against anyone who was a plan participant. Instead, the employer was motivated by a desire to reduce the taxes that would be owed had the full-time employees retained their full-time status. Accordingly, employers who did not offer benefits to large segments of their workforce prior to 2014 may have greater freedom to act to restructure their workforce in 2014 and beyond, compared to the employers that had broad benefits participation. In this area, courts will likely look at the reasons for workforce restructurings, and where there is financial necessity to cut costs, there may be greater freedom accorded to employers. In conclusion, while we anticipate that some employees may try and take legal action on these grounds, there do not appear to be any clear answers regarding the outcome of such claims.

EEO ISSUES

The ACA has been championed in many respects as a law promoting equal treatment for women, racial and ethnic minorities and assisting those suffering from disabilities.[24] Even so, from an EEO perspective, certain programs implemented under the ACA may be subject to challenge by the EEOC. In particular, employer wellness programs, which are used as a measure to contain health care costs, have come under particular scrutiny. This section of the paper primarily provides an analysis regarding wellness programs.

Under the ACA, wellness programs are generally encouraged for both large and small employers. For example, the ACA provides grants for up to five years to small employers that establish wellness programs.[25] It also permits employers to offer employee rewards in the form of discounts and waivers in connection with wellness programs and increases the amount of the incentive that can be offered.[26] However, there has already been concern expressed by disability consumer groups regarding the implementation of such wellness programs from an ADA perspective. As an example, on January 25, 2013, members of the Consortium for Citizens with Disabilities (CCD), a group of 22 national disability groups, submitted comments to the Employee Benefits Security Administration (EBSA), which

21 *Gitlitz v. Compagnie Nationale Air France*, 129 F.3d 554, 559 (11th Cir. 1997).

22 *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka and Santa Fe Railway Co.*, 117 S. Ct. 1513 (1997).

23 *Perdue v Burger King Corp*. 7 F3d 1251 (5th Cir. 1993); *Hinojosa v Jostens Inc*. 35 EBC 1881 (5th Cir. 2005) (*unpublished*), *cert. denied* 2005 WL 3027722.

24 *See* http://www.healthcare.gov/news/factsheets/index.html. Fact sheets have been issued on *The Affordable Care Act and African Americans*; *The Affordable Care Act and Latinos*; *The Affordable Care Act for Americans with Disabilities* and *The Accordable Care Act and Women*.

25 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §10408, 124 Stat. 119, 318-319 (2010), amending 42 U.S.C. 2801.

26 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1201, 124 Stat. 119, 318-319 (2010), amending 42 U.S.C. 300gg-4.

is the division of the Department of Labor partly responsible for drafting proposed rules implementing the ACA.[27] The CCD's comments concern nondiscrimination in workplace wellness programs. According to the submission, while the proposed rules included some protections for consumers, the CCD has urged the DOL to establish "clear requirements that wellness programs must comply with the Americans with Disabilities Act."[28] The CCD focuses on "the potential of wellness programs to discriminate against individuals with disabilities, particularly with the use of financial incentives and penalties tied to health status that jeopardize employee's access to affordable, quality health care."[29]

According to the CCD, Congress enacted the Act's provisions concerning wellness programs and did not insulate employers from compliance with other laws, such as the Americans with Disabilities Act (ADA), Title VII, Age Discrimination in Employment Act (ADEA) or Genetic Information Nondiscrimination Act (GINA). The CCD contends that Congress "considered and *rejected*" amendments concerning wellness programs that would have addressed that very issue.[30] The CCD thus argues, "[t]he ADA and ACA therefore must be read together and regulations implementing the wellness programs provisions of the ACA should state unequivocally that the ADA is equally applicable."[31]

To date, there has been no formal regulation or detailed guidance from the EEOC concerning wellness programs since the implementation of the ACA. However, in general, the EEOC has taken a very restrictive view concerning what is permissible under a wellness program.

A brief history of the EEOC's past informal treatment of employer wellness programs may assist in determining what the future may hold. The EEOC first addressed the topic in July 2000, when issuing guidance on disability-related inquiries, and included a "Q & A" regarding whether it was permissible for an employer to make disability-related inquiries or conduct medical examinations as part of a voluntary wellness program. The EEOC addressed the meaning of the term "voluntary" in the context of wellness programs, and expressly provided that a program will only be voluntary "as long as an employer neither requires participation nor penalizes employees who do not participate."[32] The EEOC's response underscored that "(t)he ADA allows employers to conduct *voluntary* medical examinations and activities, including voluntary medical histories…without having to show that they are job-related and consistent with business necessity," including "blood pressure screening, cholesterol testing, glaucoma testing, and cancer detections screening."[33]

In 2009, the EEOC issued numerous opinion letters regarding wellness programs.[34] In one of the earlier opinions, the EEOC stated an employer could not require its employees to take a health risk assessment (including disability-related inquiries and medical examinations) as a prerequisite for obtaining health insurance coverage. In so discussing, the EEOC stated that such a requirement "did not appear to be job-related and consistent with business necessity, and therefore would violate the ADA." In reliance on the EEOC's 2000 guidance, the EEOC further opined, "(E)ven if the health risk assessment could be considered part of a wellness program, the program would not be voluntary, because individuals who do not participate in the assessment are denied a benefit (*i.e.*, penalized for non-participation) as compared to employees who participate in the assessment."[35] In another opinion letter from August, 2009, the EEOC reiterated this opinion, stating that a wellness program that required employees to complete a health risk assessment in order to receive monies from an employer-funded reimbursement arrangement was likely violating the ADA because it penalized any employee

27 The Departments of Labor, Treasury, and Health and Human Services have jointly released proposed rules on wellness programs. *See* http://www.healthcare.gov/news/factsheets/2012/11/wellness11202012a.html.

28 *See* http://www.epilepsyfoundation.org/getinvolved/advocacy/advocacypriorities/Healthcare.cfm, which includes a copy of the January 25, 2013 letter from the CCD, which included the Epilepsy Foundation.

29 *Id*. (Jan. 25, 2013 CCD letter).

30 *Id*. (Jan. 25, 2013 CCD letter).

31 The CCD submission focuses specifically on the proposed rule that requires health-contingent wellness programs (i.e. requiring to satisfy a standard related to a health factor to obtain a reward) to allow a "reasonable alternative standard" or waiver of the other applicable standard for obtaining the reward.

32 *See* http://www.eeoc.gov/policy/docs/guidance-inquiries.html.

33 *Id*. Based on the ADA, while an employer has significant flexibility regarding medical inquiries prior to hire, so long as they are made on a consistent basis for a particular position, any medical related-inquiries after hire can only be made if they are "job related" and "consistent with business necessity."

34 In the first of the opinion letters issued in 2009, the EEOC further elaborated on what would be considered a "voluntary" wellness program, stating that a program would be considered "voluntary", "as long as the inducement to participate did not exceed twenty percent of the cost of employee only or employee and dependent coverage under the plan, consistent with regulations promulgated pursuant to the Health Insurance Portability and Accountability Act ('HIPPA')." Incredibly, the EEOC's Associate Legal Counsel withdrew this opinion, taking the view that the inquiry to the EEOC did not raise the issue. The EEOC has not revised that issue to date. *See* http://www.eeoc.gov/eeoc/foia/letters/2009/ada_disability_medexam_healthrisk.html.

35 *Id*.

who did not complete the questionnaire by making that employee ineligible to receive reimbursement for health expenses.[36] However, the EEOC qualified its opinion in one limited respect, stating that certain questions on the subject health risk assessment were not disability-related and gave examples, including whether an employee sees a personal doctor for routine care or as a healthcare directive, questions about how many servings of vegetables or fruit an employee eats, whether he takes a vitamin supplement, whether he eats breakfast and how much he exercises.[37]

In 2010, the EEOC issued final regulations implementing Title II of GINA.[38] The GINA final rule prohibits employers for offering a financial incentive for individuals to provide genetic information in connection with a wellness program. In 2011, the EEOC issued an opinion letter on wellness programs following enactment of GINA. The employer requested the EEOC to "make clear that: (1) offering incentives for participation in wellness programs does not violate the ADA or GINA; and (2) family medical history provided voluntarily may be used to guide employees into disease management programs."[39] The EEOC was non-committal regarding whether, and to what extent, Title I of the ADA allows an employer to offer "financial incentives for employees to participate in wellness programs that include disability-related inquiries (such as questions about current health status asked as part of a health risk assessment) or medical examinations (such as blood pressure and cholesterol screening to determine whether an employee has achieved certain health outcomes)." The EEOC simply stated that it would "carefully consider" the comments offered on this "important issue."[40] In dealing with GINA compliance, the EEOC's Associate Legal Counsel similarly opined that an employer "may use the genetic information voluntarily provided by an individual to guide that individual into an appropriate disease management program." However, financial incentives could not be limited. Specifically, "if that program offers financial incentives for participation and/or for achieving certain health outcomes, the program must also be open to employees with current health conditions and/or to individuals whose lifestyle choices put them at increased risk of developing a condition."[41]

Finally, in 2013, the EEOC issued another informal opinion letter regarding wellness programs.[42] Here, the employer was offering employees with certain health conditions a waiver of the health plan's annual deductible if the employee met certain requirements, such as enrollment in a disease management program or adherence to a doctor's exercise and medication recommendations. In defining the program as a wellness program, the EEOC stated that the plan could possibly comply with the EEOC so long as the employer provided reasonable accommodation, absent undue hardship, to employees who were unable to meet the outcomes or engage in specific activities due to a disability. The EEOC also stated that if reasonable accommodation was provided, it would not be unlawful to remove an employee from this "higher benefit" plan for failing to meet the plan's requirements so long as the employee could still participate in the standard benefit plan.

While the EEOC's historical treatment of wellness programs casts a potential shadow over many of these programs from an EEO perspective, particularly dealing with potential attacks under the ADA, a recent decision by the Eleventh Circuit, *Seff v Broward County*,[43] provides support for many employer wellness programs, including health risk assessments. The *Seff* case involved a class action filed against Broward County alleging a violation of the ADA based on the employer's wellness program. The wellness program consisted of two components: a biometric screening (which entailed a finger stick for glucose and cholesterol) and an online Health Risk Assessment questionnaire, which was designed to identify employees who had one of five diseases.[44] Employees with one of the diseases were offered a disease management coaching program, after which they were eligible to receive co-pay waivers for certain medications. Participation in the wellness program was not a condition for enrollment in the group health plan, but a year into the program, the employer imposed

36 *See* www.eeoc.gov/eeoc/foia/letters/2009/ada_health_risk_assessment.html.

37 *Id*.

38 75 Fed. R. 216 (Nov. 9, 2010).

39 *See* http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html.

40 *Id*.

41 *Id*. The opinion letter cited an example from the regulations: "Employees who voluntarily disclose a family medical history of diabetes, heart disease, or high blood pressure on a health risk assessment..... and employees who have a current diagnosis of one or more of these conditions are offered $150 to participate in a wellness program designed to encourage weight loss and a healthy lifestyle. This does not violate Title II of GINA.

42 *See* http://www.eeoc.gov/eeoc/foia/letters/2013/ada_wellness_programs.html.

43 *See Seff v Broward County*, 691 F. 3d 1221 (11th Cir., 2012).

44 The five diseases were Asthma, Hypertension, Diabetes, Congestive Heart Failure, and Kidney Disease.

a $20 surcharge on each biweekly paycheck for those who refused to participate.[45]

Affirming a district court's summary judgment ruling, the Eleventh Circuit held that the employer's wellness program was protected under the ADA's safe harbor provision. In essence, the safe harbor provision on the ADA does not prevent an employer from "establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law."[46] The district court held that the wellness program constituted a "term" of the employer's group health plan. The Appeals Court affirmed that the wellness program constituted a "term" of the employer's group health plan and, thus, the program fell within the ADA's safe harbor provision.

Bearing in mind this history on wellness programs, employers need to closely monitor the upcoming implementation of all provisions of the ACA in the years to come in order to spot possible EEO issues. Employers should take special care when implementing wellness programs as part of its health care program under the ACA. While mandatory risk assessment questionnaires may pose some risk based on the EEOC's longstanding view that anything other than "voluntary" questionnaires violates the ADA, the "safe harbor" provision in the ADA may be a compelling defense. Employers also should attempt to structure wellness programs so that employees are rewarded for good health, rather than being penalized due to certain health conditions, which could be viewed as disabilities under the ADA. Using the "carrot rather than the stick" approach may have favorable results so that those with medical conditions and/or conditions viewed as disabilities under the ADA may be less inclined to feel they are being penalized due to their condition.

Based on the current focus on wellness programs and the ACA, it is not surprising that the EEOC announced that it would hold a public meeting on May 8, 2013 to consider these programs. The public meeting is likely a precursor to the Commission clarifying its position on wellness programs.

Finally, while the above discussion involving EEO issues focuses primarily on potential ADA and GINA issues based on wellness programs, other EEO issues potentially may arise based on implementation of the requirements under the ACA. As an example, to the extent that an employer attempted to reduce its financial exposure by reducing the hours of certain workers and convert them to part-time status, care must be taken to avoid a potential disparate impact claim to the extent that employees in a protected class are impacted more severely than others. Whether such a theory would pass muster is open to question, but employers need to be mindful concerning the broad ramifications in implementing various aspects of the ACA.

CONCLUSION

Employers will need to use both their peripheral vision and crystal ball to determine the ultimate effect that the ACA will have on all aspects of their businesses. While important questions remain about how the ACA will impact workplace policy, this much is certain, the impact will be broader than many expect. There is no "one size fits all" approach to healthcare reform that is right for all employers. However, those who consider the full spectrum of labor, employment and benefits implications will be better prepared to meet the legal and business challenges created by the ACA.

45 The employer discontinued the program a year later, most likely due to the litigation.

46 The court cited the relevant portion of the ADA involving the "safe harbor" provision, 42 U.S.C §12201(c)(2).

Littler Mendelson Offices

Albuquerque, NM
505.244.3115

Anchorage, AK
907.561.1214

Atlanta, GA
404.233.0330

Birmingham, AL
205.421.4700

Boston, MA
617.378.6000

Charlotte, NC
704.972.7000

Chicago, IL
312.372.5520

Cleveland, OH
216.696.7600

Columbia, SC
803.231.2500

Columbus, OH
614.463.4201

Dallas, TX
214.880.8100

Denver, CO
303.629.6200

Detroit, MI*
313.446.6400

Fresno, CA
559.244.7500

Gulf Coast
251.432.2477

Houston, TX
713.951.9400

Indianapolis, IN
317.287.3600

Kansas City, MO
816.627.4400

Las Vegas, NV
702.862.8800

Lexington, KY*
859.317.7970

Long Island, NY
631.247.4700

Los Angeles, CA
Downtown
213.443.4300

Los Angeles, CA
Century City
310.553.0308

Memphis, TN
901.795.6695

Miami, FL
305.400.7500

Milwaukee, WI
414.291.5536

Minneapolis, MN
612.630.1000

Morgantown, WV
304.599.4600

Nashville, TN
615.383.3033

New Haven, CT
203.974.8700

New York, NY
212.583.9600

Newark, NJ
973.848.4700

Northern Virginia
703.442.8425

Northwest Arkansas
479.582.6100

Orange County, CA
949.705.3000

Orlando, FL
407.393.2900

Overland Park, KS
913.814.3888

Philadelphia, PA
267.402.3000

Phoenix, AZ
602.474.3600

Pittsburgh, PA
412.201.7600

Portland, OR
503.221.0309

Providence, RI
401.824.2500

Reno, NV
775.348.4888

Rochester, NY
585.203.3400

Sacramento, CA
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

St. Louis, MO
314.659.2000

Walnut Creek, CA
925.932.2468

Washington, D.C.
202.842.3400

INTERNATIONAL

Caracas, Venezuela
58.212.610.5450

Valencia, Venezuela
58.241.825.3689

Mexico City, Mexico
52.55.5955.4500

Monterrey, Mexico
52.81.8851.1211

*In Detroit, Littler Mendelson, PLC and in Lexington, Littler Mendelson, P.S.C., both are wholly-owned subsidiaries of Littler Mendelson, P.C.


Littler
Employment & Labor Law Solutions Worldwide™