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EXAMINING HOW HEALTHY CHOICES CAN IMPROVE HEALTH OUTCOMES AND REDUCE COSTS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING HOW HEALTHY CHOICES CAN IMPROVE HEALTH OUTCOMES AND REDUCE COSTS

OCTOBER 19, 2017

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EXAMINING HOW HEALTHY CHOICES CAN IMPROVE HEALTH OUTCOMES AND REDUCE COSTS

THURSDAY, OCTOBER 19, 2017

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:07 a.m. in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Murray, Isakson, Young, Cassidy, Casey, Franken, Bennet, Whitehouse, Murphy, Warren, Kaine, and Hassan.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

We have a vote at 11:45, but that should leave us an opportunity to hear from our witnesses and to have a good amount of time for questions.

I told our witnesses that I was delighted to be talking about something other than the individual health insurance market.

[Laughter.]

I am really quite serious about that because we know that the larger issues in healthcare are much more than the 6 percent of the people, every one of whom is important, who have to buy their insurance in the individual health insurance market.

We are glad to have this discussion, and it is a subject on which both Republicans and Democrats have a lot of interest, and we look forward to your advice.

Today, we are holding a hearing to look at what can be done to encourage people to make healthier lifestyle choices to help prevent serious illnesses and reduce healthcare costs.

Senator Murray and I will each have an opening statement, and then we will introduce the witnesses. After the witnesses' testimony, Senators will each have 5 minutes of questions.

Let me say, before I begin, that I want to thank Senator Murray for her leadership and being a straightforward, tough negotiating partner on our efforts to present to the Senate a limited, bipartisan bill to stabilize the insurance market during 2018 and 2019.

She and I will go to the Senate floor today at one o'clock and make a brief statement, and put the text of the legislation in the Congressional Record so Senators can examine it. We will also list

a significant number of Republican and Democratic co-sponsors for the legislation.

The hope is, now that we have put a proposal on the table, that the Senate will consider it, that the house will consider it, and the President will consider it.

I talked with the President last night, and he encouraged the process, which he asked me to begin, and said he looked forward to considering it. I said, "If you have suggestions for improving it, that is certainly your prerogative to do," and that is what we would expect to happen in the legislative process.

I thank Senator Murray for that, and other Members of the Committee, who have been involved in it.

Over the last 7 years, we have endured this political stalemate over the Affordable Care Act, with most of the disagreement being over, as I said, a very small part of the health insurance market where 6 percent of Americans buy their insurance.

The fact that we have had that stalemate makes this even more refreshing to talk about an area of healthcare on which most Americans—doctors, employers, Republicans, Democrats—agree. That consensus is that a healthy lifestyle leads to longer and better lives, and reduces the Nation's healthcare costs.

According to the Centers for Medicare and Medicaid Services, healthcare spending in the United States has grown from consuming 9 percent of the Gross Domestic Product in 1980 to nearly 18 percent, or $3.2 trillion, in 2015 and a predicted 20 percent in 2025.

The Cleveland Clinic, which is represented by one of our witnesses today, has said if you achieve at least four of six normal measures of good health and two behaviors, you will avoid chronic disease about 80 percent of the time.

The six indicators of good health are familiar: blood pressure, cholesterol level, blood sugar, Body Mass Index, smoking status, and your ability to fulfill the physical requirements of your job.

The two behaviors are seeing your primary care physician regularly and keeping immunizations up to date.

Again, if you hit four of the six indicators and keep up the two behaviors, according to the Cleveland Clinic, you will avoid chronic diseases 80 percent of the time.

This is important because we spend more than 84 percent of our healthcare costs, or $2.6 trillion, treating chronic diseases. That is something on which almost everyone agrees.

Let us add that to another obvious fact: about 60 percent of Americans get their health insurance on the job. So if we really want to focus on improving the quality of healthcare in America, why not connect the consensus about wellness to the insurance policies that 178 million Americans get from their job? That is precisely what the Affordable Care Act sought to do in 2010. In fact, it was one of the only parts of the ACA that everybody seemed to agree on.

Today's hearing is about how successful wellness initiatives have been, and what we can do to make it easier to encourage people to lead healthier lives and reduce healthcare costs.

Many employers have developed wellness programs to incentivize people to make healthier choices. These programs may reward be-

haviors such as exercising, eating better, quitting smoking, or offer employees a percentage of their insurance premiums for doing things like maintaining a healthy weight or keeping their cholesterol levels in check.

These programs have the potential to save employers money, and improve the health and well-being of their employees.

Steve Burd, one of our witnesses, as CEO of Safeway, visited with many of us a few years ago, and started a successful employee wellness program after he left Safeway, which I hope he will talk about. That is one part of it.

I would also like to hear about what communities and the Federal Government are doing to encourage healthy lifestyle choices.

I know that Blue Cross Blue Shield of Tennessee partnered with local, state, and private organizations to fund community-level initiatives across our state, such as Fitness Zones in Chattanooga, programs in rural counties to promote healthy habits, and an interactive elementary school program to keep kids moving.

An example of encouraging wellness at the Federal level is the Medicare Diabetes Prevention Program, an intervention program for Medicare recipients diagnosed as pre-diabetic to prevent Type 2 diabetes. Medicare spent an estimated $42 billion more in 2016 on people with diabetes than it would have spent if those recipients did not have diabetes.

There are other ways to encourage healthier behavior, but it is hard to think of a better way to make a bigger impact on the health of millions of Americans than to connect the consensus about wellness to employer-based insurance for 178 million people.

I look forward to the hearing.

Senator MURRAY.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you very much, Chairman Alexander.

Thank you to all of our colleagues and witnesses for joining us today.

We often think of healthcare as something you need when you get sick, but we should be thinking a lot more about ways we can help prevent families from getting sick in the first place and ending up in the doctor's office or the hospital.

I am really glad that we are having today's hearing on how to better promote health and wellness. Because the truth is we all have a role to play in supporting families' efforts to make healthy choices, whether it is Government, or communities, or hospitals, or schools; and certainly, businesses and employers who can promote healthy behaviors in partnership with their communities.

I look forward to a robust discussion today around wellness and public health efforts that promote physical activity, improve access to healthy and affordable food, especially for our children, expand on science-based ways to reduce tobacco use, and a lot more.

I will be focused on making sure Congress is providing the investments needed to support local, state, and Federal efforts to promote public health. That includes grant programs by the Centers for Disease Control and Prevention that invest in community health centers, as well as the Prevention and Public Health Fund,

which has made a difference for so many patients and families nationwide.

Given our Nation's high healthcare costs, and the fact that so many of those costs can be attributed to chronic diseases, it is critical we do more to support public health efforts focused on health education and promotion.

I do want to be clear on the following: while we consider wellness programs, we have to do it in a balanced manner and make sure that we are protecting workers' civil rights and privacy.

For me, and I know for a lot of my colleagues, the fact that employer wellness programs could impose significant financial penalties on workers, who do not wish to share protected health information, is a very serious concern.

I want to hear today more about what we need to do to make sure we find this right balance for wellness programs that protects workers' rights under the Americans with Disabilities Act, and HIPAA, and the Genetic Information Non-discrimination Act, three laws that were written and passed by this Committee.

I have to be clear: responsibility for making sure that the rights of workers with disabilities, and those who do not wish to share genetic information, are protected and respected in these programs will rest with the Trump EEOC.

That is exactly one of the reasons why Democrats pushed so hard against his recent nominees to the EEOC, nominees who, I really am concerned, do not show they were truly committed to protecting those workers from discrimination.

This is a balance, and we need to work on it, and figure it out.

I really appreciate all of our witnesses who are here to help share your information with us, and I look forward to the discussion.

Mr. Chairman, I do have a letter from AARP that I want to submit for the record as well.

The CHAIRMAN. Thank you. It will be submitted.

Thanks, Senator Murray.

We would ask each witness to please summarize your remarks in about 5 minutes. That will give us more time to have questions back and forth from Senators.

The first witness is Steve Burd, Founder and CEO of Burd Health. He was CEO of Safeway for 20 years, and many of us met him when he roamed the halls during the debate on the Affordable Care Act, both the Democratic and Republican halls, with a message about wellness.

Second, we will hear from Dr. Michael Roizen, the Chief Wellness Officer and Founding Chair of the Wellness Institute at the Cleveland Clinic, a program that I just described in my opening remarks.

Dr. David Asch, is Executive Director of Penn Medicine Center at the Health Care Innovation, and John Morgan Professor, Perelman School of Medicine and the Wharton School at the University of Pennsylvania. He is a Leading Behavioral Economist with much research on healthy lifestyle choices.

Then, Jennifer Mathis is Director of Policy and Legal Advocacy at the Judge David L. Bazelon Center for Mental Health Law. She supervises the Center's policy work and engages in advocacy.

Why do we not start with you, Mr. Burd?
Welcome.

STATEMENT OF STEVE BURD

Mr. BURD. All right. Well, thank you. Thank you very much.

I think the first thing I would like to say is that I very much appreciate the opportunity to share my experience in the wellness category with the Committee here. I really want to applaud your willingness to work in a bipartisan fashion to improve the health of Americans and ultimately legislation that attaches to that.

I am going to go quickly through a little bit of background of what I have done since I left Safeway in the CEO position because it has impacted how I think about the subject.

Second, I want to talk about why we picked wellness as a real important area.

Third, I am going to cover the elements of the wellness program that we introduced at Safeway. I think it is most instructive because we have had a 10-year run. We know what the statistics look like after some 10 years.

I am going to speak to the results that we achieved, which I think are extraordinary, and I think indicative of what others can do.

Then finally, I want to talk about what I think are the five keys to success in a company wellness plan because most people have failed at this. I know that Michael and I, and maybe others here that will testify, have succeeded. I think you will find some common success elements.

After leaving Safeway, while at Safeway as the Chairman indicated, I got very involved in healthcare and discovered that it was a fascinating area; a great opportunity to improve the health of Americans, opportunity to improve care without adding to costs, and frankly, an opportunity to dramatically lower costs. I committed to spending the next 10 years of my life, and I have now spent four, in this space.

What I wanted to do was to tell you briefly what my company does is we do three things that are unique.

We are able to lower a company or organization's costs, actually 40 to 50 percent, simultaneously lower the employee's expense about 6 to 10 percent.

We are also capable of significantly improving the care they receive.

If they are willing, we can have a dramatic effect on the wellness of their population, which has profound effects on the productivity of that workforce.

I picked wellness back in 2008 because we took note that about 70 percent of all healthcare costs are driven by healthcare behavior. So we thought as a self-insured employer with the right to design a plan however we chose, we could actually affect behaviors and people would become healthier.

I want to just put into context for you, because I know you will, at some point, want to understand how to reduce costs. That, in the short run, there are other ways to reduce costs more significantly. The first one I would mention would be provider efficiency, then plan discipline, plan design, and then wellness.

In the first 5 years, I have put wellness in the fourth place. In the next five to 10 years, I would put it probably close to second place or third place. So there is an opportunity there.

On the wellness front, we put together a program at Safeway and we made it a voluntary program, which I am not sure everybody understood at the time. Eighty Five percent of our employees opted-in to this plan, and 70 percent of the spouse's opted-in to this plan.

We rewarded people for achieving certain biometric standards with about $600 worth of reward. When we polled people, as we did annually, about 78 percent of the participants viewed the program as either very good or excellent. What we measured was blood pressure, HbA1c, cholesterol, tobacco use, and BMI.

As I said, the results were amazing, and I will give you a 2-year look after starting the program.

Of the people that failed the blood pressure standard, 2 years later, 73 percent of them passed and they maintained that over the balance of the program.

Pre-diabetics, of those that failed initially, 45 percent of them passed 2 years later.

Cholesterol level, 43 percent of those passed 2 years later.

Smokers, I have a number of 35 percent. In fairness, you can beat that test and so while we did improve the smoking, 35 percent is a bit strong.

Then we took the obesity rate of our population of 28 percent down to 21 percent. I had a goal to be, if we were a state, we would be the lowest obesity state in the United States. Senator Bennet, at that time, Colorado held that position. When I left in 2013, we matched Colorado at 21 percent.

I want to just move, shift quickly, because it says I have 9 seconds left.

Why did we succeed?

First of all, we rewarded on outcomes, not participation. The vast majority of programs, they say they are outcome-based. They are not. They are participation-based.

We had to put a meaningful amount of money at stake. We viewed that starting point as about $600.

We needed to provide support tools that would allow people to actually change their behavior and enhance their state of health.

We needed to surround it with an ecosystem that constantly convinced the employee that we cared about their health. We can talk more about that in the Q and A.

Then, we consciously developed a culture of health and fitness. I did this when I was about 57 years of age, and I understood that my fitness level down the road was going to determine my state of health. Once you become immobile, your health begins to decline. So we focused on health and fitness.

Then last, it needs leadership and I practice this with clients today. If you do not have CEO leadership, it just does not work.

I would contend, you cannot pick three of the five. In my experience, you have to do all five.

[The prepared statement of Mr. Burd follows:]

"Examining How Healthy Choices Can Improve Health Outcomes and Reduce Costs"
Briefing Material for the United States Senate HELP Committee Hearing – October 19, 2017

Steve Burd – CEO, Burd Health and Former Chairman and CEO, Safeway Inc.

Burd Health

After serving 20 years as CEO of Safeway, Inc. I founded Burd Health, a healthcare solutions company in late 2013. Burd Health was formed to build on and expand the work we pioneered at Safeway to transform healthcare delivery. We are unique in the healthcare sector and there is no one that does what we do. We help self-insured companies: (1) lower healthcare spend for both the company (40-50%) and employees (6-10%) without cutting any benefits, (2) secure better care, and (3) if desired, we help improve the health of the workforce. The same techniques we use with our private sector clients would also work well in the public sector, and could potentially relieve much of the pressure to develop a balanced budget.

Focus of This Hearing

The focus of today's hearing is to examine how a well-structured health plan can improve wellness and help lower cost for both plan sponsors and individuals. Given that 70% of healthcare spend is driven by behaviors, employers can have a powerful impact on both employee health and healthcare costs. In our experience, wellness efforts contribute more to cost reduction in a 5-10-year timeframe than they do in 1-5 years. In the near term, there are easier and quicker ways to lower cost. The biggest near-term opportunity is (1) improving provider efficiency, followed by (2) plan discipline and (3) plan design (Chart 1).

Wellness Results at Safeway

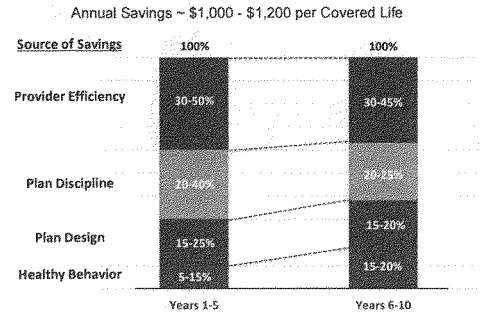
The work we did at Safeway is probably the most instructive example of our long-term wellness results. We began transforming healthcare delivery at the company in 2005, and at that time offered a modest reward for self-declared non-smoking status. This approach had no impact on population health status. In 2008, we introduced the Healthy Measures program. This program included five biometric measures and rewarded employees and spouses when they met or exceeded these standards. The program was completely voluntary, and 85% of employees and 70% of spouses participated. Initially we set the reward at $600 per year and the average participant earned $400. When polled annually, 78% of participants rated the program very good to excellent.

The results were outstanding. Of the participants who initially failed a biometric standard, two years later a significant percentage passed the same biometric: Blood pressure (73%), blood sugar for pre-diabetics (45%), cholesterol (43%), tobacco free (35%), and non-obesity (21%) (Chart 2). The Safeway obesity rate plunged from an already low 28% to 21%, while the national rate, the highest in the world (Chart 3), continued its steady and alarming increase (Chart 4). By improving behavior, our workforce actually reduced its biological age by 4 years.

In the 2 years after I retired as CEO, healthcare costs continued to decline by 9% per year with no material changes in plan design. Safeway's health actuaries reported this continued cost reduction was due predominately to improved health status.

I look forward to discussing these results – and any other questions – with members of the HELP Committee.

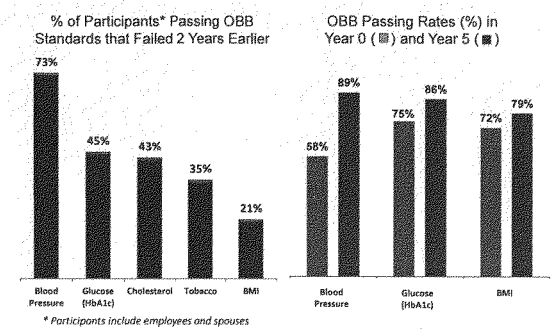
Typical Composition of Savings from a Burd Health Solution



Burd Health

Chart 1

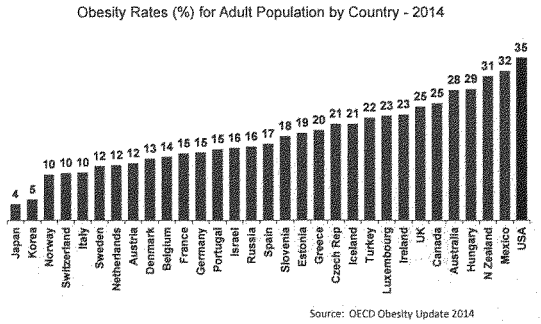
Outcome-Based Biometrics Results



Burd Health

Chart 2

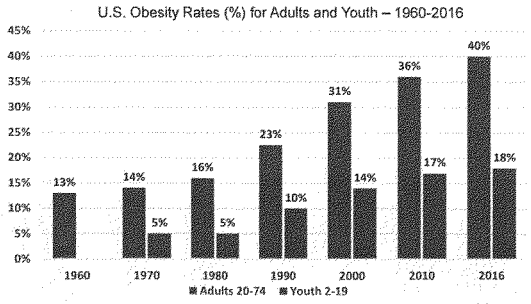
The U.S. Has The Highest Obesity Rate in The World



Burd Health

Chart 3

Significant Increase in U.S. Obesity Rates Since 1960



Burd Health

Chart 4

The CHAIRMAN. Thank you, Mr. Burd.

Dr. Roizen, welcome.

STATEMENT OF MICHAEL F. ROIZEN

Dr. ROIZEN. Thank you.

Chairman Alexander, Ranking Member Murray, and Members of the Committee.

My name is Dr. Mike Roizen, and I thank you for the opportunity to testify today before your Committee.

Since 2007, I have served as the Chief Wellness Officer at the Cleveland Clinic. In this capacity, I lead the Clinic's work in preventing illness and helping people live longer, healthier lives.

We give people more time. Keeping people well, and enabling them to live their best lives, is not just my professional goal, it is my passion, my life's work, and the passion of the Cleveland Clinic.

Thank you for your leadership in holding this important hearing. In fact, the title of the hearing encapsulates the Cleveland Clinic's story. That is, how healthy choices can improve health outcomes and substantially reduce medical costs.

We are hopeful that sharing the results of our efforts over the last 9 years can demonstrate that we, as a Nation, can have real impacts on the health of our people while resulting in hundreds, literally hundreds of billions of dollars in savings for both the private sector and the Federal Government.

For years, the central healthcare debate in Washington has been about what role government should play in providing health insurance. If leaders in Washington do not address the skyrocketing costs of healthcare caused by the influx of chronic disease, it will not matter whether Medicare, Medicaid, private insurance, or individuals pay the bills.

Everyone in this room has seen the CBO estimates. Unless we do something to bend the cost curve, we will all be bankrupt from this influx of chronic disease that is growing five to seven times faster than the population.

There is, however, something that both the Federal Government and private insurers could do right now to significantly reduce healthcare costs across the country, a step that could save our Nation hundreds of billions over 10 years and with voluntary participation.

Nine years ago, the Cleveland Clinic began an ambitious experiment to improve the health and wellness of its employees and their families.

The Clinic's Rewards for Healthy Choice program provides employees, who voluntarily choose to do so, much like Mr. Burd, with compensation for reaching several outcomes, wellness outcomes and medical outcomes, that you mentioned, each year.

The program is born of a few key insights about the causes of chronic disease and the drivers of healthcare spending.

It starts with the fact that 84 percent of all healthcare costs are due to chronic disease and 75 percent of chronic diseases are driven by six measurable factors: your blood pressure; your Body Mass Index; your fasting blood sugar or hemoglobin A1c; your LDL cholesterol; whether you smoke or not, we measure it by urine cotinine levels; and unmanaged stress.

These six predictors of chronic disease are controllable in well over 90 percent of individuals. The Cleveland Clinic Rewards for Healthy Choice program focuses on helping its 100,000 employees and dependents get and keep these six measurements normal; combined with encouraging those two additional behaviors: seeing a primary care provider regularly and keeping immunizations up to date.

The Clinic program helps employees get these six normals. The way we do it is we pay employees; that is, we incentivize employees. We ended up—we started very small—but ended up by increasing payments to about the same number as Mr. Burd to achieve the six normals and the two behaviors.

The upshot, since the onset of the program, the Cleveland Clinic has saved $254 million in direct medical costs increasing yearly. This year we will save over $150 million more versus the Milliman Benchmark as more of our employees get and stay healthy. Further, their improved health is reflected in substantial reductions in unscheduled sick leave.

The 62 percent of Clinic employees who voluntarily participate in the program have seen their healthcare costs and premiums decrease now by $600 for individuals to $2,000 annually for families for hitting these targets.

Smoking rates have decreased from 15.4 to under 5 percent while the state of Ohio is around 23 percent.

Body Mass Index of employees, for all 100,000 employees taken together, is decreasing 0.5 percent per year as opposed to the Nation's increasing 0.37 percent per year.

Blood pressure, LDL cholesterol, and hemoglobin A1c levels have improved substantially resulting in over an 11 percent decrease in the need for illness care since 2009 rather than the expected and projected 20 percent increase due to our aging population.

The Cleveland Clinic model has been replicated with our help by nine other large employers, all of whom have seen similar impressive results. For example, Lafarge, a national construction supply company, is saving over 46 percent of expected medical costs as estimated by Aetna. We know that other organizations can learn from these examples.

In short, the Cleveland Clinic Rewards for Healthy Choice program is doable, exportable, and scalable across the country.

The Clinic has been working to educate lawmakers on this idea, and Senators Ron Wyden and Rob Portman are collaborating to work in the Senate Finance Committee aimed at reducing the costs and improving health of Medicare beneficiaries.

It does not have to stop with federal programs. Private sector programs, supported by this Committee, could benefit by the work we have pioneered.

This program has at least three critical virtues. It has been tested in multiple settings across different populations and patient groups, everything from engineers to blue collar workers. It is entirely voluntary, and it enables the Federal Government to achieve substantial cost savings without any of the programmatic budget cuts and without any initial costs.

Bending the cost curve through voluntary wellness and incentive programs is a commonsense idea that both Democrats and Repub-

licans should be able to rally around for both the health of our Nation's finances and the health of our people, and it increases our competitiveness for jobs.

Thank you.

[The prepared statement of Dr. Roizen follows:]

Cleveland Clinic

Testimony Capsule – Michael F. Roizen, Cleveland Clinic

The title of today's hearing encapsulates the Cleveland Clinic story, that is, how healthy choices can improve health outcomes and reduce costs. Cleveland Clinic is hopeful that sharing its journey over the last 9 years can demonstrate that the nation can make very positive and real impacts on the health of people while resulting in billions of dollars in savings for both the private sector and the federal government.

The culture of wellness at the Cleveland Clinic has generated remarkable results that have led to shared benefits – healthier, happier employees, as well as lower costs for their self-funded insurance program, and lower costs for our employees and for the communities and patients we serve. At the root of the Cleveland Clinic's success - employees have voluntarily (with substantial incentives for 6 healthy outcomes) chosen to get and to stay healthy. Today, more than 62% of their employees participating in the hospital system's Healthy Choice incentive programs. That participation has saved Cleveland Clinic over $254 million dollars in the last seven years.

More importantly, the overall health of the employees has improved dramatically, with unprecedented successes in controlling Hemoglobin A1C, Cholesterol, Asthma, and Blood Pressure. Cultural shifts in the organization have resulted in steady, year-over-year weight management success, even in employees who are not enrolled in formal weight management programs. Smoking rates have dropped by more than 10% in 9 years.

This model for success is not limited to the Cleveland Clinic. A formula such as this can be used to achieve savings in other companies, and that any business, large or small, self-insured, or part of a group market, can benefit from the lessons the system has learned. Those savings can mean better health and more money in the pockets of the employees and taxpayers in this country.

Cleveland Clinic

Testimony of Michael F. Roizen, MD to the Senate HELP Committee

Chairman Alexander, Ranking Member Murray, members of the committee, my name is Dr. Mike Roizen and I thank you for the opportunity to testify today before the Committee to share the Cleveland Clinic story. Since 2007, I have served as the Chief Wellness Officer at the Cleveland Clinic. In this capacity, I lead the Cleveland Clinic's work in preventing illness and helping people live longer, healthier lives. Keeping people well and enabling them to live their best lives is not just my professional goal. It is my passion, my life's work, and the passion of the Cleveland Clinic. Thank you for your leadership in holding this important hearing.

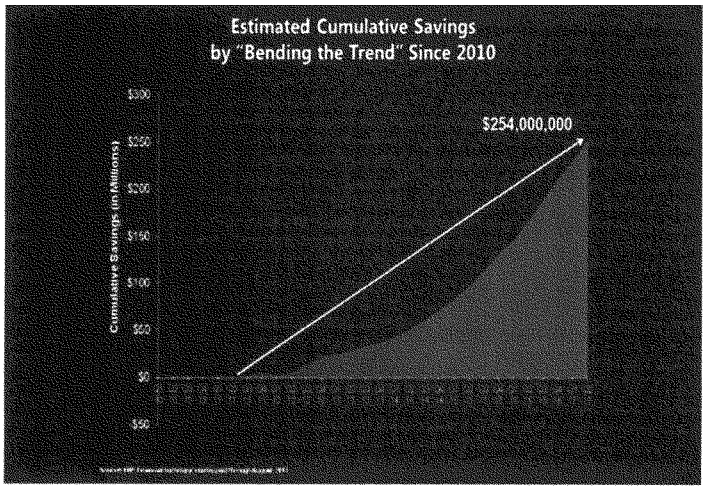
The title of today's hearing encapsulates the Cleveland Clinic story, that is, how healthy choices can improve health outcomes and reduce costs. We are hopeful that sharing our journey over the last 9 years can demonstrate that we as a nation can make very positive and real impacts on the health of people while resulting in billions of dollars in savings for both the private sector and the federal government. And, today, I look forward to providing this committee with insight regarding how our work can be replicated by private employers around the country.

Cleveland Clinic is an internationally-recognized provider of health care services. The 2017 US News and World report ranked Cleveland Clinic as the number 2-ranked hospital in the nation, with recognition in more than a dozen specialties.

In addition to being Ohio's highest-ranked hospital, we are also its second-largest employer. Across our enterprise, we employ roughly 50,000 clinicians, caregivers, and other staff. I am proud to be part of an institution that prides itself not only on the health of its patients, but also the health of our workforce.

The culture of wellness at the Cleveland Clinic has generated remarkable results that I will highlight for you. That commitment has led to shared benefits – healthier, happier employees, as well as lower costs for our self-funded insurance program, and lower costs for our employees and for the communities and patients we serve. At the root of our success - our employees have voluntarily (with substantial incentives for 6 healthy outcomes) chosen to get and to stay healthy. **Yes, we pay our employees to get and stay well.** Today, we have more than 62% of our employees participating in our Healthy Choice incentive programs. That participation has saved Cleveland Clinic and those we serve over $254 million dollars in the last seven years.

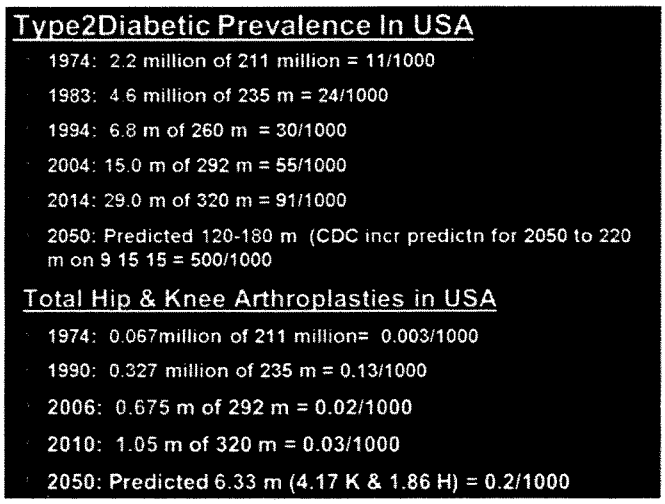
This model for success is not limited to the Cleveland Clinic. We have shown that a formula such as this for achieving saving can be replicated in other companies, and that any business, large or small, self-insured, or part of a group market, can benefit from the lessons we have learned. Those savings can mean better health and more money in the pockets of the 172 million employees and taxpayers in this country.



Cleveland Clinic believes in starting a national dialogue about how best to reduce the cost of providing healthcare. The simple fact is that if our nation is going to reduce the cost of health care, we need to deliver that health care more efficiently, and we need to focus on getting and keeping people well.

Imagine if the majority of Americans took steps to live their best life and, in turn, minimized the suffering and costs associated with preventable chronic diseases.

The fact is that chronic disease is a major driver of cost to our economy and is **increasing 5-7 fold faster** than the population is growing as seen in these charts . Reversing this trend is not easy, but as I'm about to show you, it's far from impossible.



Cleveland Clinic's Employee Health Plan

Like many large employers, Cleveland Clinic offers comprehensive health coverage to full time employees – and has for decades. In 2017, Cleveland Clinic's Employee Health Plan (EHP) covered nearly 100,000 lives.

In 2005, Cleveland Clinic had a problem that is all too common for employers across the nation. The costs for our employee health plan were growing at an unsustainable rate. At the same time, the health outcomes of our employees, including the rates of chronic diseases, obesity, and smoking among our employees, reflected the same rates in the general public. Our Per-Member, Per-Month (PMPM) costs were increasing at a rate of 7.5% per year. Without a significant change in course, we faced difficult choices, including drastic cuts to the benefits for our then enrolled 60,000+ employees and their family members or begin charging premiums in excess of cost of living adjustments

In 2007, we put a plan in motion to do something about it.

We undertook many of the "conventional" cost-saving measures. We identified the biggest cost drivers and conditions in the system. We began developing standardized care paths to tackle variations in care, which reduced costs for things like imaging in patients with back pain. We developed contracts for our durable and disposable medical goods.

As we made these changes, we were cognizant that a bigger shift in culture was needed. To really bend the cost curve, we needed to shift our model from paying to treat sick people to investing in keeping people well.

A 2009 American Journal of Public Health study provided evidence that the medical community had long suspected: that bringing five critical health metrics within normal healthy levels could reduce the incidence of chronic disease and drastically reduce overall health care costs, even after accounting for the cost of the preventive medical interventions. Helping all of our employees achieve specific measures related to these "Five Normals" -- LDL Cholesterol less than 130, Hemoglobin A1C less than 7%, BMI of less than 27, Blood pressure less than 140/90, and no tobacco use – became an enterprise goal.

We quickly recognized, as well, that these Five Normals are almost impossible to reach in an individual dealing with chronic stress, so we added stress management as a "Sixth Normal." We had a new care objective.

We launched the Healthy Choice plan for our employees in 2009, and it's changed the way we approach wellness at the Cleveland Clinic and for those we serve.

We started by providing our employees and their dependents free wellness, stress-management, smoking cessation and weight loss services. We partnered with organizations like Weights Watchers and Curves, and started offering yoga and meditation and guided imagery on campus to any caregiver who wanted to attend.

The uptake of the initial program was somewhat encouraging. However, only 11% of our covered employees took advantage of these programs. We learned many of those 11% were beneficiaries already engaged in managing their own health.

We also made what was then considered the "radical" decision to stop hiring smokers. We test new potential hires now for the presence of cotinine in their blood – a marker for nicotine use – and delay the hiring of smokers while they undergo smoking cessation classes and medications. Those who complete a smoking cessation program are then eligible for hire.

Taken alone, these changes didn't drastically shift health outcomes or impact top line costs. However, they represented a first step in changing our culture. Our employees started seeing a message that said "We are a workplace where wellness is valued."

Next, we made modifications to the food and drinks available on campus. We eliminated sugar-sweetened beverages from our cafeterias and vending machines. We launched a new brand – go! Foods – that highlighted foods that were low in sodium, fat and sugar. We included a visual sticker on foods that met our wellness criteria so employees and visitors alike could make healthier food choices. Flyers and posters with reminders about dietary needs were placed near the cafes. We started ensuring that every café had at least one "healthy" entrée and side dish every day. Healthier options were highlighted in signage and placement in the cafes, and the pizzas and burgers were made healthier and relegated to the back of the line.



We even took the nearly unheard-of step of deciding not to renew the contract we had with the McDonald's that had been in our main hospital for more than a decade.

We encourage employees and visitors to incorporate exercise into their daily routines in small and sustainable ways. "Take the Stairs" or "Free Exercise" signs are placed in front of stairwells and near elevators. Hallways are outfitted with walking maps and mile markers, so employees walk and exercise indoors during the snowy Cleveland winters. Managers in administrative areas are encouraged to schedule walking meetings when appropriate, to both encourage exercise to advanced wellness team-building and stress reduction into the daily routine. Today, every hallway inside a Cleveland Clinic property is decked out with visual reminders that everyday wellness is at the heart of our Cleveland Clinic culture.

However, our core question remained how to get all plan enrollees engaged and focused on their "Six Normals." We offered some modest financial incentives to those who enrolled in weight loss, smoking cessation, or chronic disease care coordination programs. We sent out emails and made phone calls to employees who had one or more conditions that didn't meet the "Six Normals," including obesity, tobacco use, diabetes, high blood pressure, and elevated cholesterol, encouraging them to enroll in disease management programs. Today every employee is offered voluntary access to a choice of multiple managed care programs, where they receive coaching, medication management, stress management, and provider consultations free of charge.

Current Framework for the Cleveland Clinic Plan

In 2011, we continued to our journey toward employee engagement, and established an aggressive reward and incentive plan with our Plan beneficiaries. We gave each and every employee an opportunity to receive up to a 30% discount by either enrolling in a disease management plan, if they had a chronic condition, or participating in regular exercise or other wellness plan if they had healthy benchmarks.

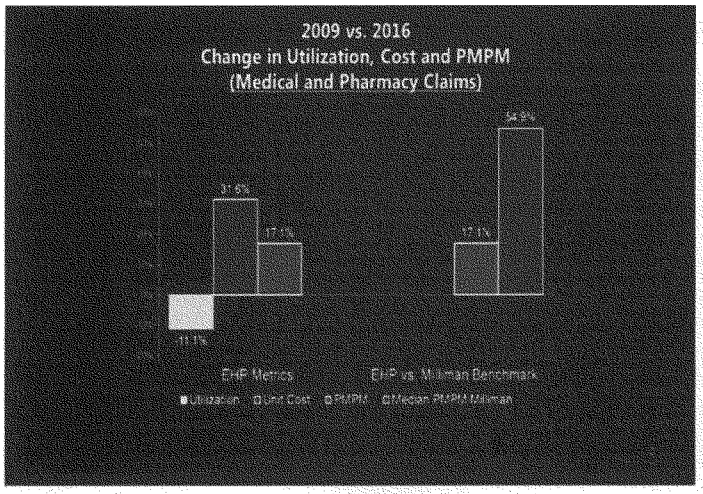
The response from our employees was dramatic: participation in our Healthy Choice program rose by more than 20% in the first year. In 2014, we extended the incentive program to include both employees and their spouses. Now we have achieved a participation rate for employees and spouses above 62%.



Today, the costs to take care of the 100,000+ members of the Cleveland Clinic Employee Health Plan are no longer growing. The EHP's net rate of cost-growth over the last four years has been almost flat at 0.6%. That's right: it costs almost the same per member per month to take care of our members today as it did in 2013. That figure reflects the total cost of care to the Cleveland Clinic including the incentive payments, the medical and pharmacy cost claims, and all administrative costs.

Hospitalization rates for chronic diseases such as asthma, diabetes, and high blood pressure have dropped profoundly. Hypertension inpatient admissions per 1,000 have dropped more than 22%; asthma emergency department visits by more than 16%. Chronically ill enrollees, through timely outpatient visits and medication compliance, are getting healthier, and taking control of their own health outcomes.

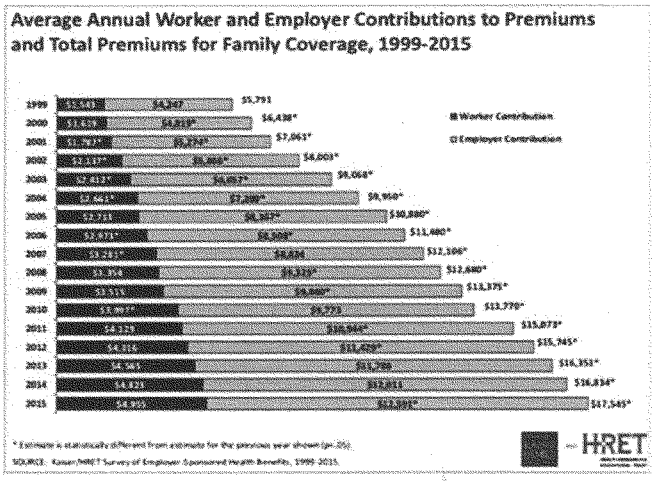
Over the last 7 years, we have saved a cumulative $254 million in total costs over what we projected based on that initial 7.5% annualized growth rate. These astounding savings have been achieved during a time when the cost per unit has risen at market rates. That is, while the rate per cost-adjusted unit of care has risen by 31.6% since 2009 (as it has nation-wide), our utilization has dropped by over 11% across the same time period. That translates to only a 17.1% total increase in PMPM over the last 8 years, versus a National Milliman Benchmark increase of 54.9%. Significantly, this is during a time when our per-member pharmaceutical costs have increased by nearly 70%.



But the cost benefits to our self-insured health plan pale in comparison to the health benefits our employees and their spouses have gained over the same period. Our members with diabetes have seen a 20% improvement in the percentage with Hemoglobin A1C scores to less than 8%, with a more than 50% improvement in the percentage with LDL Cholesterol scores less than 100mg/dL. Plan members who are enrolled in the weight management program consistently lose an average of 2 pounds per year, versus a 1.5 pound weight gain per person in the general public. And significantly, the cultural changes have resulted in an average 0.5 pound-per-year weight loss in our overweight employees who are not participating in the program. And the smoking rate has decreased from 15.4% in 2005 to 4.3% today.

Medication compliance among our plan members who have a chronic disease is among the highest in the CVS Health/Caremark Employer book of business, which tracks more than 1200 employers nationwide.

This culture shift has a positive impact on patient experience as well as on employees as our caregivers became more confident discussing lifestyle management with patients. Bottom line is this: wellness and the prevention of chronic disease is now a way of life at the Cleveland Clinic and can be for America, with resultant massive increases in savings for corporations, individuals and the federal government.



As employers, the benefits of this improved health are not limited to dollars and cents saved in premiums and direct medical expenses. Since putting the Healthy Choice program in place with our employee health plan, the rate of unplanned absence among our employees has dropped substantially. Our employees are less likely to get sick, and we are more productive. Employee engagement scores are improving and turn-over is down.

When we observed the PMPM trends among commercial insurance plans, which have put similar effort into utilization and case management, we see that their costs have increased on average 4-5% over the last five years, at the same time that our costs have increased an average of 0.6%, including incentive and administrative costs. We believe we can attribute this additional savings to having a more activated and engaged beneficiary pool, with incentives in place that have achieved overall better health.

The savings are also tangible for the plan enrollees. They save money on premiums, co-pays, and lost wages. And not only is **the plan voluntary** but it also **decreases income inequality** caused by the rise in out of pocket, and employer insurance costs. Most importantly, the plan pays off for employees in improved quality of life.

A Blueprint for the Country

Cleveland Clinic's successes are real. We have healthier employees, and we have lower costs associated with providing health benefits. The journey was not easy and it required a long view. But this is a meaningful template for the country. This plan is exportable. But we think this is a template that the majority of the 172 million workers and individuals who are responsible for their own or a dependent's coverage, and those covered by government programs can use.

As this committee considers ways to reduce the burden of disease through investments in health and wellbeing, the Cleveland Clinic would be pleased to serve as a resource. The Healthy Choice Plan is a meaningful template for all Americans.

While I understand this Committee's jurisdiction does not include Medicare, I believe I would be remiss in not mentioning the great work being done by Senators Wyden and Portman to introduce legislation extending the Cleveland Clinic's Healthy Choice program to Medicare. We are grateful for their leadership.

Thank you again for holding this hearing to advance the national dialogue on wellness care. I look forward to answering your questions.

The CHAIRMAN. Thank you, Dr. Roizen.
Dr. Asch, welcome.

STATEMENT OF DAVID A. ASCH

Dr. ASCH. Chairman Alexander, Ranking Member Murray, and distinguished Members of the Committee.

Thank you for the opportunity to speak with you today.

My name is David Asch, and I am a practicing physician and a professor at the University of Pennsylvania. I am here to talk about workplace health programs and their role in the Nation's health.

My summary message is this: I believe that employer-sponsored wellness programs have value to contribute.

I believe that even though the health and financial benefits of these programs are often overstated. I believe that even though some of these programs, and the ways they are currently designed, risk treating some employees unfairly.

I am optimistic about these programs going forward because we are learning how to design them to be much more effective and much more fair.

Americans spend most of their time outside of the healthcare system. Even those with a chronic illness spend only a few hours a year in front of a doctor.

We spend about 5,000 waking hours a year doing everything else in our lives. It is during those 5,000 hours when so many of the determinants of our health unfold: how we eat, whether we exercise, smoke, or take our prescribed medications.

We can put more and more money into healthcare, but much of our health is determined in the 5,000 waking hours outside the reach of doctors and hospitals.

Americans spend many of those waking hours at work and employers have a large financial incentive to advance health, not just because of our system of employment-based health insurance, but also because healthier workers are more productive.

More than three-quarters of large employers now have some sort of workplace wellness program targeting risk factors, that you have heard about already, that account for much of chronic illness. Risk factors like tobacco use, high blood pressure, obesity, and the like.

Unfortunately, it is a lot easier to know what conditions to target than it is to know how to do so. Managing these conditions requires substantial behavioral change.

Our Nation has invested considerably in the science of medical treatment, as it should, but less in the science of behavioral change. Our knowledge of how to break old habits and develop healthier ones is rudimentary, but it is getting better.

Behavioral economics is one example of how we are learning more about changing behavior. Just last week, Richard Thaler, of the University of Chicago, won the Nobel Prize in economics for recognizing that we all succumb to irrational tendencies that compete with our long term goals.

Increasingly, behavioral economics has been used to help doctors and patients make better decisions. I am proud to say that the University of Pennsylvania is a world leader in this field.

One such irrationality is called loss aversion. We are much more motivated to avoid $100 loss than we are to achieve $100 gain. It does not make economic sense, but it is how humans tend to think.

We found this recently when encouraging overweight employees at a large firm to increase their fitness. In one group, employees were given $1.40 for each day that they walked at least 7,000 steps. That is a standard, economic, financial incentive.

For another group, we structured it as a loss, $1.40 a day is $42 a month. So in that group, we gave each employee $42 at the beginning of the month and we took away $1.40 for every day they did not walk 7,000 steps.

An economist would see those two designs as the same. For every day you walk 7,000 steps, you are $1.40 richer.

It turned out that those who received $1.40 were no more likely to walk 7,000 than those who received no incentive at all.

Those who had $1.40 taken away if they did not walk 7,000 steps were 50 percent more likely to succeed.

Mathematically and financially, these two approaches are the same, but one worked and the other did not.

Most large companies are using financial incentives to encourage healthy behaviors. The vast majority of them do so by adjusting the premiums their employees pay for their health insurance.

Although it may seem obvious that charging higher premiums for being a smoker or being overweight would encourage people to modify their habits, there is little evidence that programs designed that way often work. At best, they provide modest financial benefits to employers and unclear health benefits to employees.

These programs offer promise, but they also draw criticism.

I remain, nevertheless, excited about well-designed programs that help Americans change the behaviors they want to change: help them quit tobacco, help them lose weight, and help them better manage their high blood pressure.

Those changes are much less likely to come from typical premium-based financial incentives and much more likely to come from approaches that reflect the underlying psychology of how people make decisions encouraged by frequent rewards, emotional engagement, contests, and social acceptance. Those are the ingredients of successful programs and they are missing from most of what employers currently do.

We know so much more about how to design financial and other incentives to motivate human behavior far more now than even 10 years ago. I have not seen much of this new knowledge applied effectively by employers, but there is no reason why it cannot be.

Thank you for inviting me to testify.

I look forward to your questions.

[The prepared statement of Dr. Asch follows:]

PREPARED STATEMENT OF DAVID A. ASCH

- I believe that employer sponsored wellness programs have value to contribute—even though the health and financial benefits of these programs are frequently overstated, and even though some of these programs—in the ways they are currently designed—risk treating some employees unfairly. I am optimistic about these programs going forward, because we are learning how to design them to be much more effective and much more fair.
- More than three quarters of large employers now have some sort of workplace wellness program to eliminate the use of tobacco, reduce obesity, or manage

other risk factors for chronic disease. Most large companies are using financial incentives to encourage healthy behaviors. The vast majority of them do so by adjusting the premiums their employees pay for their health insurance.

• Although it may seem obvious that charging higher premiums for being a smoker or being overweight would encourage people to modify their habits, there is little evidence that programs designed that way actually work. Those that do seem to work provide modest financial benefits to employers and unclear health benefits to employees.

• Managing these conditions requires substantial behavioral change and behavioral change is hard. ehavioral economics is an example of one way we are learning more about changing behavior, and it offers promise for how to design better programs in the future. The Penn Center for Health Incentives and Behavioral Economics is 1 of 2 NIH-funded Centers on behavioral economics and health and the world's leader in designing programs to improve consumer health behaviors.

• I'm excited about *well-designed* programs that help Americans change the behaviors they want to change: help them quit tobacco, help them lose weight, help them better manage their high blood pressure. Those changes are much less likely to come from typical premium-based financial incentives and much more likely to come from approaches that reflect the underlying psychology of how people make decisions—encouraged by frequent rewards, emotional engagement, contests, social acceptance. These are the ingredients of successful programs and they are missing from most of what employers currently do.

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SUMMARY STATEMENT OF DAVID A. ASCH

Chairman Alexander, Ranking Member Murray, and distinguished Members of the Committee:

Thank you for the opportunity to speak with you today. My name is David Asch. I am a physician, and a professor at the University of Pennsylvania.

I am here to talk about workplace health programs and their role in the nation's health. My summary message is this: I believe that employer sponsored wellness programs have value to contribute. I believe that even though the health and financial benefits of these programs are often overstated. I believe that even though some of these programs, in the ways they are currently designed, risk treating some employees unfairly. I am optimistic about these programs going forward, because we are learning how to design them to be much more effective and much more fair.

Americans spend most of their time outside of the health care system. Even those with a chronic illness spend only a few hours a year with a doctor. We spend 5,000 waking hours each year doing everything else in our lives. It is during those 5,000 hours when so many of the determinants of our health unfold: how we eat, whether we exercise, smoke, or take our prescribed medications. We can put more and more money into health care, but much of our health is determined in the 5,000 waking hours outside the reach of doctors and hospitals.[1]

Americans spend many of those waking hours at work. Employers have a large financial incentive to advance health, not just because of our system of employment-based health insurance, but also because healthier workers are more productive.

More than three quarters of large employers now have some sort of workplace wellness program, targeting risk factors that together account for most chronic illness. These include:

- Eliminating the use of tobacco
- Controlling high blood pressure
- Reducing obesity
- Increasing exercise
- Lowering cholesterol
- Managing diabetes

Unfortunately, it is a lot easier to know what conditions to target than to know how to do so. Managing these conditions requires substantial behavioral change.

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[1] Asch DA, Muller RW, Volpp KG. Automated hovering in health care: watching over the 5,000 hours. N Engl J Med. 2012;367:1-3.

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Increasingly, behavioral economics has been used to help doctors and patients make better decisions. I'm proud to say that the University of Pennsylvania is a world leader in this field.

One such irrationality is called loss aversion. We are much more motivated to avoid a $100 loss than we are to achieve a $100 gain. It doesn't make economic sense, but it is how humans tend to think.

We found this recently when encouraging overweight employees at a large firm to increase their fitness.[2] In one group, employees were given $1.40 for each day they walked at least 7,000 steps. That's a standard economic financial incentive. For another group, we structured it as a loss. $1.40 a day is $42 a month. So, in that group, we gave each employee $42 at the beginning of the month and we took away $1.40 for every day they didn't walk 7,000 steps. An economist would see these two designs as the same: for every day you walk 7,000 steps, you are $1.40 richer. It turned out that those who received $1.40 were no more likely to walk 7,000 steps than those in a control group that received no financial incentive. However, those who had $1.40 taken away if they didn't walk at least 7,000 steps were 50 percent more likely to succeed. Mathematically and financially, these two approaches are the same, but one worked and the other didn't.

Most large companies are using financial incentives to encourage healthy behaviors. The vast majority of them do so by adjusting the premiums their employees pay for their health insurance.

Although it may seem obvious that charging higher premiums for being a smoker or being overweight would encourage people to modify their habits, there is little evidence that programs designed that way often work.[3] At best they provide modest financial benefits to employers and unclear health benefits to employees.

These programs offer promise but they also draw criticism. One criticism is that they can be seen as coercive. Programs are more likely to be seen as coercive to the extent they put a lot of money at risk, whether in the form of rewards or penalties. I think that problem is avoidable. Most current employer programs are based on the idea that the more money you put at risk, the more effective the incentive. That's a mistake based on outdated economic thinking and it can create unfairness. We've designed programs that trade on psychological principles of behavioral economics that are often much more effective than programs putting considerably larger amounts of money at risk. Those designs can be more effective, and they can be fairer.

In general, the key fairness question is this: How much can the behaviors we most want to target be modified through incentive programs and how much are we just punishing the people with those behaviors?[4]

To the extent these programs are not effective at changing behavior, then all they are doing is cost-shifting. Employees who smoke or are obese tend to be the poorest, and they will end up paying the highest rates. That kind of cost-shifting just moves around the money, and it is regressive.

I remain excited about well-designed programs that help Americans change the behaviors they want to change: help them quit tobacco, help them lose weight, help them better manage their high blood pressure. Those changes are much less likely to come from typical premium-based financial incentives and much more likely to come from approaches that reflect the underlying psychology of how people make decisions—encouraged by frequent rewards, emotional engagement, contests, social acceptance. These are the ingredients of successful programs and they are missing from most of what employers currently do.[5]

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[2] Patel MS, Asch DA, Rosin R, Small DS, Bellamy SL, Heuer J, Sproat S, Hyson C, Haff N, Lee SM, Wesby L, Hoffer K, Shuttleworth D, Taylor DH, Ulrich V, Zhu J, Yang L, Wang X, Volpp KG. Framing financial incentives to increase physical activity among overweight and obese adults—a randomized, controlled trial. Ann Intern Med. 2016;164:385-94.

[3] Volpp KG, Asch DA, Galvin R, Loewenstein G. Redesigning employee health incentives—lessons from behavioral economics. N Engl J Med. 2011;365:388-90.

[4] Loewenstein G, Volpp KG, Asch DA. Incentives in health: Different prescriptions for physicians and patients. JAMA. 2012;307:1375-6.

[5] Asch DA, Rosin R. Engineering social incentives for health. N Engl J Med. 2016;375:2511-3.

We know so much more now about how to design financial and other incentives to motivate human behavior—far more now than even 10 years ago. I haven't yet seen much of this new knowledge applied effectively by employers but there's no reason why it can't be.

Thank you for inviting me to testify today. I look forward to your questions.

The CHAIRMAN. Thank you, Dr. Asch.

Ms. Mathis, welcome.

STATEMENT OF JENNIFER MATHIS

Ms. MATHIS. Thank you.

Chairman Alexander, Ranking Member Murray, and Members of the Committee.

I appreciate the opportunity to testify about this important issue. My name is Jennifer Mathis and Chairman Alexander noted my position at the Bazelon Center for Mental Health Law.

I am here also as a representative of the Consortium for Citizens with Disabilities, or CCD, a coalition of over 100 national disability organizations that work together to promote public policy, ensuring the self-determination, independence, empowerment, integration, and inclusion of adults and children with disabilities in all aspects of society.

I appreciate the breadth of the topic for this hearing. Obviously, there are many different ways that we can promote healthy choices that improve health outcomes and reduce costs, and many different stakeholders who can do so.

The primary concern that animates this hearing seems to be the role of employer-based wellness programs. I also think it is important to mention the role of state service systems. Particularly those for people with disabilities and older adults in planning and administering service systems in a way that expands opportunities for independence, choice, and autonomy; enabling people to exert more control and participate actively in their own healthcare, direct their own lives, and work.

We have seen from numerous studies over many years that realigning service systems to offer people with disabilities the chance to live, work, and receive services in their own communities leads to improved health outcomes and also lowers cost.

I am happy to answer any questions about that, but I will focus the rest of my comments on workplace wellness programs.

CCD has supported the development of wellness programs as a tool to improve life and health outcomes. Those programs can, and must, operate in a way that respects longstanding and important workplace protections, such as those provided by the Americans with Disabilities Act, or ADA, and the Genetic Information Nondiscrimination Act, or GINA, especially workplace privacy protections. People with disabilities need these protections.

The employment rate of people with disabilities is much lower than that of any other group tracked by the Bureau of Labor Statistics. They are employed at less than half of the rates of people without disabilities.

Study after study that has examined why the employment rate of people with disabilities is so low cites attitudinal barriers as one of the chief reasons. Perceptions that people with disabilities are incapable continue to be pervasive including in our workplaces.

It was precisely for that reason that when Congress passed the ADA, one of our most important civil rights laws for people with disabilities, it created strict protections to enable employees to keep their health and disability-related information confidential in the workplace.

Employees could be subjected to medical exams or inquiries only if they were job-related, or if they were voluntary inquiries that were part of an employee health program. GINA provided similar protections for employees' genetic information including their spouse's health information.

Removing or weakening those hard-won protections would make many people with disabilities vulnerable in their workplaces and expose them to the risks that Congress meant to avoid.

Last year, the EEOC significantly rolled back the protection that it had enforced for many years to ensure that employers could not penalize employees for declining to provide their health information as part of a wellness program.

The agency, instead, permitted steep financial penalties for employees who choose to keep their health information private and more steep penalties if their spouses chose to keep their health information private, making this choice far from a voluntary one for many people.

A Federal judge has now ruled that the agency violated the law and failed to provide a reasoned justification for this change in position.

The agency now has an opportunity to revisit its regulations and do the right thing to afford people the rights guaranteed by the ADA and GINA.

We believe it is not difficult for the EEOC to ensure that wellness programs serve to promote the healthy choices and healthy outcomes while respecting important civil rights of people with disabilities.

The agency set out a path for doing this in its 2010 regulations implementing GINA, clarifying that financial incentives can be used, but not for questions asking for genetic information. The same rule should apply to questions about seeking health information of an employee or a spouse.

The lead study on wellness programs conducted for the Department of Labor highlighted many strategies other than incentives that have made wellness programs more effective.

Good wellness programs can be designed without eroding the civil rights of people with disabilities and we will all be better served if that happens.

Thank you.

[The prepared statement of Ms. Mathis follows:]

PREPARED STATEMENT OF JENNIFER MATHIS

Thank you for inviting me to testify concerning this important issue. My name is Jennifer Mathis. I serve as Director of Policy and Legal Advocacy at the Bazelon Center for Mental Health Law, a national non-profit organization that works to promote equal opportunities for individuals with mental disabilities in all aspects of life through litigation, policy advocacy and public education. I am here also on behalf of the Consortium for Citizens with Disabilities (CCD), the largest coalition of national organizations working together to advocate for Federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

Since the Committee's topic is broad, I will address employer-sponsored wellness programs as well as describing some ways in which broader health service delivery systems can and have promoted healthy choices that result in better health outcomes and reduced costs.

Workplace Wellness Programs May Hold Potential to Improve Health Outcome and Reduce Costs, but Must Not Erode Critical Workplace Protections for People with Disabilities

Employer-sponsored wellness programs have become increasingly prevalent as employers look for ways to reduce employee health care costs. According to the Kaiser Family Foundation, 90 percent of large companies that offer health benefits offer some type of wellness program.[1] These programs may include health risk assessments and biometric screenings, as well as classes or other activities to help employees stop smoking, lose weight, or adopt healthier lifestyles or to manage chronic diseases such as diabetes.

While CCD believes that employer-based wellness programs have potential to promote individuals' health and well-being, we believe it is critical that such programs be administered in a way that does not undermine the workplace protections that Congress provided to employees with disabilities and their spouses in the Americans with Disabilities Act (ADA) and the Genetic Information Non-discrimination Act (GINA). These laws—both enacted with overwhelming bipartisan support—were adopted in response to a long history of workplace discrimination based on disability and on genetic information. They are important tools to help ensure fair workplaces for people with disabilities. In particular, they provide workplace privacy protections that enable people with disabilities to keep their health information private if it is not related to their ability to do their job, and to keep their spouses' health information private.

People with disabilities need these protections. The employment rate of people with disabilities has remained far lower than that of any other group tracked by the Bureau of Labor Statistics. Among working age adults, the employment rate of people with disabilities is less than half of that for people without disabilities.[2] This Committee has reported about the importance of efforts to improve this situation. In addition, the need to increase employment of people with disabilities has been a concern and a priority for Federal agencies including the Department of Labor, the Department of Justice, the Department of Health and Human Services, the Equal Employment Opportunity Commission, and others. Against this backdrop, it is particularly important to ensure that employer-based wellness programs are implemented in ways that promote healthy behaviors without eroding longstanding and critical workplace protections for people with disabilities.

While the research over the last several years has consistently shown that the early assessments of workplace wellness programs' effectiveness in improving health outcomes and achieving cost savings appear to have been overblown,[3] the primary concern of the disability community has been the need for fair treatment by these programs. Whatever their utility, these programs should not punish people for having disabilities or pressure people to disclose sensitive health or disability information unrelated to their ability to do their jobs. The Affordable Care Act (ACA) and its implementing regulations provide some protection against wellness program incentives that punish people for having disabilities; where a program offers financial incentives to participants who meet a health standard or engage in an activity, the ACA requires that the program allow a person to meet a reasonable alternative standard if the person's medical condition makes it "unreasonably difficult" or "medically inadvisable" to meet that health standard or engage in the activity.[4]

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[1] Karen Pollitz & Matthew Rae, Henry J. Kaiser Family Foundation, Changing Rules for Workplace Wellness programs: Implications for Sensitive Health Conditions, at 2 (April 2017), *http://files.kff.org/attachment/Issue-Brief-Changing-Rules-for-Workplace-Wellness-Programs.*

[2] U.S. Department of Labor, Bureau of Labor Statistics, Persons with a Disability: Labor Force Characteristics Summary (June 21, 2017) (among persons age 16 to 64, the employment-population ratio in 2016 for people with disabilities was 27.7 percent, in contrast to 72.8 percent for people without disabilities), *https://www.bls.gov/news.release/disabl.nr0.htm*.

[3] S*ee, e.g.*, Soeren Mattke et al., RAND Health, Workplace *Wellness Programs Study*: *Final Report* (2013), *https://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf*; Soeren Mattke et al., RAND Corporation, *Workplace Wellness Programs Services Offered, Participation, and Incentives* (2014), *https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/WellnessStudyFinal.pdf*; Jill R. Horwitz et al., *Wellness Incentives In the Workplace*: *Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 Health Affairs 468 (2013); Adrianno McIntyre et al., *The Dubious Empirical and Legal Foundations of Wellness Programs*, 27 Health Matrix 59 (2017).

[4] U.S.C. § 300gg-4(j)(3); 26 C.F.R. § 54.9802-1, §§ (f)(3)(iv), (f)(4)(iv). The ADA also requires that reasonable accommodations be provided, absent undue hardship, to enable employees with disabilities to earn whatever financial incentive an employer offers in a wellness program. The

Concerns remain, however, about the use of wellness program incentives that are used to pressure employees to give up their rights to keep their own health information and their spouse's health information private.

The ADA Requires Workplace Wellness Program Medical Inquiries and Exams to be Voluntary

The Americans with Disabilities Act (ADA) prohibits employers from subjecting employees to medical inquiries or exams that are not job-related and consistent with business necessity, unless they are "voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site."[5]

The ADA's medical inquiries provisions are part of a detailed scheme that Congress enacted to limit employer access to medical information from employees and applicants. Such limits are a core protection of the ADA. Due to the prevalence of negative attitudes about people with disabilities—including assumptions that they are not capable—Congress recognized that the best way to prevent discrimination was to ensure that employers simply did not have this information unless it was related to someone's job performance. See S. Rep. 101–116, at 39–40 (1989) ("An inquiry or medical examination that is not job-related serves no legitimate employer purpose, but simply serves to stigmatize the person with a disability. . . . As was abundantly clear before the Committee, being identified as disabled often carries both blatant and subtle stigma. An employer's legitimate needs will be met by allowing the medical inquiries and examinations which are job-related.").

As the EEOC noted in its guidance concerning disability-related inquiries of employees:

Historically, many employers asked applicants and employees to provide information concerning their physical and/or mental condition. This information often was used to exclude and otherwise discriminate against individuals with disabilities—particularly non visible disabilities, such as diabetes, epilepsy, heart disease, cancer, and mental illness—despite their ability to perform the job. The ADA's provisions concerning disability-related inquiries and medical examinations reflect Congress's intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employers to ensure that individuals in the workplace can efficiently perform the essential functions of their jobs.[6]

For many years, the EEOC defined "voluntary" wellness program medical inquiries and examinations to mean that an employer may neither require participation nor penalize employees who do not participate.[7] In 2016, however, the agency abandoned that interpretation and issued regulations providing that such inquiries and examinations are "voluntary" if the wellness program incentives for answering or participating do not exceed 30 percent of the cost of employee-only health insurance premiums. Such incentives would penalize employees who chose to exercise their privacy rights with penalties that could in many cases amount to thousands of dollars. At their maximum, these penalties would approximately double the amount that employees would have to pay for their health insurance. A Federal judge has since concluded that the agency failed to provide any reasoned justification for or evidence supporting its new position.[8]

GINA Requires that Workplace Wellness Program Medical Inquiries of Employees' Spouses be Voluntary

GINA provides similar protections barring employers from requesting, requiring or purchasing employees' genetic information, including medical information of their spouses, with a similar exception for workplace wellness program requests that are voluntary. The EEOC's implementing regulations define voluntary to mean that an employer may neither require employees to provide genetic information nor penalize

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reasonable accommodation requirement will often be satisfied by the provision of a reasonable alternative or waiver of the standard or activity. 29 C.F.R. Part 1630 Appx., § 1630.14(d)(3): *Limitations on Incentives*.

[5] 42 U.S.C. §§ 12112(d)(4)(A), (d)(4)(B). *See also EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act* (July 27, 2000) at Question 22, *http://www.eeoc.gov/policy/docs/guidance-inquiries.html ("EEOC Guidance").*

[6] *EEOC Guidance*, General Principles.

[7] EEOC Guidance, Question 22. While the guidance speaks of "voluntary wellness programs" rather than "voluntary medical inquiries" or "voluntary medical examinations," it construes the ADA's text relating to "voluntary medical examinations, including voluntary medical histories" that are part of an employee health program. It is clear that the guidance refers to penalties for answering questions or undergoing medical exams.

[8] 31AAARP v. *EEOC*, Case No. 1:16-cv-02113-JDB, Memorandum Opinion (D.D.C. Aug. 22, 2017).

employees who decline to provide it.[9] When the EEOC changed its rules concerning the ADA's application to wellness programs, it also changed its rules concerning GINA's application, defining voluntary requests for the health information of an employee's spouse to allow financial incentives of up to 30 percent of the cost of employee-only health insurance premiums.[10] These incentives would be in addition to any incentives for disclosure of the employee's health information, with the potential to create astronomical increases in the cost of health insurance for families. The same Federal court that concluded that the agency failed to provide a reasoned justification or evidence supporting its new interpretation of "voluntary" under the ADA reached a similar conclusion about the agency's new interpretation of "voluntary" under GINA. The court remanded both rules to the agency, which must now revise its rules or provide appropriate support for them.

The EEOC now has an opportunity to revamp its regulations to ensure that employer efforts to promote employee wellness proceed without damaging the employment prospects of people with disabilities.

Penalizing the Exercise of Health Privacy Rights Damages the Employment Prospects of Workers with Disabilities

Such a "wellness-or-else" approach places significant pressures on many employees with disabilities to make unwanted disclosures of their health information, potentially putting their jobs at risk. Even though employers are not supposed to receive individually identifiable health information when a wellness program is run by a third party vendor, that protection offers little comfort to employees in employer-run programs, and to employees in small workplaces where it is not difficult to connect knowledge that someone has a particular disability with the employee in question. Furthermore, data breaches of sensitive information are not uncommon. Given the widespread attitudinal barriers that continue to hold people with disabilities back from securing, maintaining, and advancing in employment, extracting steep financial penalties for employees who exercise their right to keep health information confidential damages the employment prospects of people with disabilities.

Other Avenues to Improve Wellness Programs

We should be encouraging other means of improving wellness programs' effectiveness rather than encouraging steep financial penalties to try to force people to participate in wellness programs, including turning over sensitive health information. Notably, the principal author of the Federal Government-sponsored RAND study—the lead study on wellness program effectiveness—stated:

> *Why do employees, and in particular those at high risk, choose not to participate? We do not yet have the evidence or insight to understand and convincingly answer that question. When we do, we will be able to design attractive and accessible programs. In the meantime, we should not penalize vulnerable employees who are reluctant to join marginally effective programs.*[11]

The RAND study, which included almost 600,000 employees at seven employers, found that well designed wellness programs succeed in promoting employee participation without the use of incentives. The study notes that comprehensive programs with genuine corporate and manager engagement in wellness, and commitment to monitoring and evaluating programs, tend to succeed. By contrast, limited programs, such as those that only use health risk assessments to glean information about employees' health, tend not to inspire participation without the use of incentive and tend not to reduce costs or improve health.[12]

The RAND study offered important guidance about factors that have demonstrated success in wellness programs. Those include, for example: clear communication about the goals of the particular wellness interventions being used, ensuring that the program's activities are convenient and easily accessible for all employees and consistent with their schedules, ensuring that the program's activities are aligned with employee preferences, soliciting ongoing feedback from employees, continuous evaluation of the program, strong support from leadership, and making full use of existing resources and relationships.

These strategies, rather than eviscerating important workplace privacy protections, should be the focus of wellness program development.

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[9] 29 C.F.R. § 1635.8(b)(2).

[10] C.F.R. § 1635.8(b)(2)(iii).

[11] Soeren Mattke, When It Comes To the Value of Wellness, Ask About Fairness Not Just About Effectiveness, Health Affairs Blog (Mar. 18, 2015), *http://healthaffairs.org/blog/2015/03/18/when-it-comes-to-the-value-of-wellness-ask-about-fairness-not-just-about-effectiveness/*.

[12] Mattke 2013, *supra* note 3.

State Service Delivery Systems for People with Disabilities Can Expand Opportunities for Healthy Choices that Improve Health Outcomes and Reduce Costs

The Committee's examination of the impact of healthy choices on health outcomes and costs implicates many more areas than employer-based wellness programs, which play a relatively small role in this sphere. For example, state service systems have a critical role to play in enabling healthy choices that improve outcomes and reduce costs. The investments that states choose to make, and the manner in which they administer service delivery systems, have a significant impact on the available choices for people with disabilities to improve their health, and have significant potential to reduce health care costs.

A key example of state strategies to promote healthy choices is the strategy of reallocating disability service system resources to decrease reliance on costly institutional services and expand home and community-based services, consistent with the ADA's "integration mandate". Expanding availability of key community-based services that enable people with significant disabilities to live in their own homes, participate in their communities, secure and maintain employment, and maintain health and well-being not only improves health outcomes but also significantly reduces costs.

This Committee has held a number of bipartisan hearings in recent years to explore the progress of states in implementing the ADA's integration mandate. While those hearings demonstrated that we continue to have a long way to go in realigning service systems to promote independence and choice, they also underscored the importance of the shift toward community integration. The implementation of the integration mandate that has occurred in some states has demonstrated the improved health outcomes, improved life outcomes, and reduced costs realized through expanding community services and reallocating public service system dollars from costly institutional care to support people instead in their own homes and communities.

Below are examples of two states that achieved significant service system transformations as a result of their efforts to implement the integration mandate.

Delaware, through a settlement agreement entered with the U.S. Department of Justice, expanded core community services for people who received psychiatric inpatient care or emergency room care through public programs, who were homeless, or had a history of arrests or incarcerations. The development of this community capacity resulted in a decrease in the average census of the state psychiatric hospital by more than 55 percent—from 136 in Fiscal Year 2010 to 76 in 2016.[13]

In 2015, Delaware regularly diverted over 70 percent of individuals in crisis from acute psychiatric beds into less expensive community crisis services.[14] Delaware also achieved a significant expansion in the number of people with serious mental illness receiving employment supports and working, quadrupling the percentage of individuals in the target population who were employed.[15] Many thousands of individuals with serious mental illness have received needed community services and avoided institutionalization because of the service expansions and policy changes undertaken.

In New Jersey, an agreement between the state and the state protection and advocacy system, Disability Rights New Jersey, was reached in 2009 to develop community services for hundreds of people who remained institutionalized in state psychiatric hospitals even though they had been determined to no longer need hospital care, due to the lack of community alternatives—as well as hundreds more who were at risk of admission to state psychiatric hospitals. New Jersey committed to provide these individuals with the services they need to live independent, integrated lives in the community.

The state developed 1436 new supported housing units for individuals waiting to be discharged from the state hospitals and for those at risk of admission to these facilities. It successfully discharged 294 of the 297 individuals who had been awaiting discharge for more than 1 year. In addition, New Jersey significantly reduced the length of time for which individuals remained hospitalized due to the lack of community services, ensuring more prompt discharges.

As a result of the increased access to supported housing and other services, New Jersey reduced admissions to psychiatric hospitals by one third between 2006 and 2010, a rate that has remained steady over subsequent years. In 2016, admissions

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[13] Tenth Report of the Court Monitor on Progress Toward Compliance with the Agreement: *U.S.* v. *State of Delaware*, U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS (Sept. 19, 2016), *https://www.ada.gov/olmstead/documents/de__10th__report.pdf.*

[14] *Id.*

[15] *Id.*

had declined 36 percent from 2006 and the average daily census within state hospitals declined by 33.7 percent. The average daily census of the state psychiatric hospitals also shrunk by 34 percent, from 2,122 in 2006 to 1,406 in 2016.[16]

In addition, the number of individuals remaining in state psychiatric hospitals due to the lack of community options has shrunk by more than two-thirds since 2006. In 2006, these individuals comprised nearly half of all state hospital residents, whereas in 2016, they comprised only 22 percent of state hospital residents.[17] The reduction in hospital beds has enabled the state to achieve a very significant expansion of community services. Over roughly the same period, the number of individuals served in the community has grown by almost 60,000 people.[18] Supported housing is now the most common setting for individuals discharged from New Jersey's state psychiatric hospitals who need a place to live upon discharge.

Such system realignment efforts have also been undertaken to afford individuals in nursing homes, institutions for individuals with intellectual and developmental disabilities, and board and care homes to live more independently in their own homes and communities. This type of systems change allowing people to exercise greater control over their own lives, and in many instances, to secure and maintain employment, is an important aspect of enabling people to make healthy choices, improve health outcomes, and reduce costs. Any examination of efforts to advance healthy choices should include the role of state service systems in addition to the role of employers in doing so.

The CHAIRMAN. Thank you, Ms. Mathis.

We will now have a round of 5 minute questions. We will start with Senator Young.

STATEMENT OF SENATOR YOUNG

Senator YOUNG. Thank you, Mr. Chairman.

I am very excited about this hearing because I know a number of our witnesses have discussed in their testimonies behavioral economics and behavioral decisionmaking.

I think it is really important that we, as policymakers, incorporate how people really behave, not according to an economist per se or according to other policy experts, but based on observed behaviors. Oftentimes, we behave in ways that we do not intend to. It leads us to results that we do not want to end up in.

Dr. Asch, I will start with you, with your expertise in this area. You have indicated behavioral economics is being used to help doctors and patients make better decisions, and you see an opportunity for employers to help Americans change their behaviors in ways they want; from tobacco mitigation, to losing weight, to managing blood pressure.

You indicate those changes are much less likely to come from typical premium-based financial incentives and much more likely to come from approaches that reflect the underlying psychology of how people make decisions encouraged by frequent rewards, emotional engagement, contests, social acceptance, and so forth.

Then you said in your verbal testimony, you have not seen much of this new knowledge applied effectively by employers, but there is no reason why it cannot be.

My question for you, sir, what might employers learn from behavioral economists, just in summary fashion?

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[16] New Jersey Dep't of Human Services, Division of Mental Health & Addiction Services, Home to Recovery 2, 2017-2020, A Vision for the Next Three Years (Jan. 2017),at 12, 13, *http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/Home%20to%20Recovery%202%20Pla%20-%20January%202017.pdf*.

[17] *Id.*

[18] New Jersey Dep't of Human Services, Division of Mental Health & Addiction Services, Realignment of the NJ Mental Health System (powerpoint, July 1, 2015).

Dr. ASCH. Well, thank you, Senator.

I will start by saying that there is a misunderstanding often about behavioral economics and health. Many people believe that if you use financial incentives to change behavior, you are engaged in behavioral economics.

I would say no. That is just economics. It becomes behavioral economics when you use an understanding of our little psychological foibles and pitfalls to sort of supercharge the incentives and make them more potent so that you do not have to use incentives that are so large.

There are a variety of approaches that come from behavioral economics that can be applied in the employment setting and elsewhere.

I mentioned one, which is capitalizing on the notion that losses loom larger than gains might be a new way to structure financial incentives in the employment setting in ways that might make it more potent and more palatable, and easier for all employees to participate in programs to advance their health.

The delivery of incentives more frequently, for example, or using contests, or certain kinds of social norming where it is acceptable to show people on leader boards, and contests, and get people engaged in fun toward their health.

All of these are possibilities.

Senator YOUNG. Thank you very much.

You really need to study these different phenomena individually, I think, to have a sense of the growing body of work that is behavioral economics. So we need to increase awareness and the education of many employers about some of these tics we have and that seems to be part of the answer.

In fact, Richard Thaler, who just won the Nobel Prize for his groundbreaking work in this area, indicated that we, as policymakers, ought to have on a regular basis, not just lawyers and economists at the table as we are drafting legislation, but we ought to have a behavioral scientist as well.

In the U.K., they have the Behavioral Insights Team. The United States, our previous Administration, had a similar sort of team that did a number of experiments to figure out how policies would actually impact individuals' health, and wellness, and a number of other things.

Some of the ideas that I think we might incorporate into the Government context, and tell me if any of these "pop" for you, if you think they make sense.

We need to continue to have a unit or units embedded within Government that do a lot of these experiments.

We need to have a clearinghouse of best practices that others, employers included, might draw on. This does not have to be governmental, but it could certainly be.

We, on Capitol Hill, might actually consider, aside from having a Congressional Budget Office, we might have an entity or at least some presence within the CBO of individuals who understand how people would actually respond to given proposals.

Do any, or all of those, make sense to you?

Dr. ASCH. Well, thank you for your remarks.

I think they all make sense to me and one of the lessons that, I guess, I have repeatedly learned is that seemingly subtle differences in design can make a huge difference in how effective a program can be, and how it is perceived, and that we ultimately care about the impact of these programs.

So, I am very much in favor of a greater use of these programs, but in addition, greater study of these programs because, I think, we need an investment in the science. That will help all of us get better at delivering these activities not just in healthcare, but in other parts of society.

Senator YOUNG. Makes a lot of sense.

I am out of time. Thank you.

The CHAIRMAN. Thank you, Senator Young.

Senator Murray.

Senator MURRAY. Thank you.

Dr. Roizen, I want to start with you.

We have heard a lot today about workplace wellness programs. As I mentioned, I think it is critically important we think about how the investments we make in our communities can also play a critical role in making the healthy choice the easy choice for our families in this country.

In my home State of Washington, we have seen a lot of these really critical efforts in our schools, for example. We are investing in physical education, and healthy food, and beverage preparation.

In our cities and towns, we are working to make the environment more accessible to all users: bicycles, pedestrians, people of all ages and abilities.

Our healthcare providers are making it easier to quit smoking and taking steps to better support breastfeeding, for example.

Our communities of color are taking strides to ensure strong culturally competent programs to promote the health of people in my state.

I wanted to ask you. Do you agree, Ms. Mathis mentioned it, in addition to these workplace-based programs, community-based efforts where health and wellness are also important?

Dr. ROIZEN. The answer is I absolutely agree.

Your state and your schools are taking a leadership role that the rest of the Nation would love to follow and hopefully will be able to.

What I mean by that is when you get kids to be healthy and, in fact, influence their parents to be healthy, when you get food manufacturers to make foods for large distribution to your schools that are healthy, you really get to change the health of a whole generation.

We totally applaud that. We work with that. In fact, I go and we have a network of what we call inner and outer ring schools around Cleveland. It is very hard to get appropriate products for the school lunches, et cetera, and breakfast.

Your state is taking a lead in that and we thank you.

Senator MURRAY. Well, thank you.

Ms. Mathis, I wanted to ask you. As you well know, a Federal District Court recently held that the EEO Commission failed to support its rules on wellness programs.

Those rules said that an employee's decision not to participate in a wellness program was voluntary so long as the employee did not have to pay a penalty greater than 30 percent of the cost of health insurance; in other words, thousands of dollars.

That high of a penalty is a problem for the millions of employees and their spouses who do not wish to risk disclosure of genetic information or the existence of a disability by participating in wellness programs that do collect, of course, sensitive health information.

It is a person's right. It is a right under the ADA. It is a right under the Genetic Information Nondiscrimination Act, and under HIPAA. Those are, as I said, three laws this Committee wrote and I am proud of.

As you may well know, this Committee met yesterday and cleared for the full Senate the Trump Administration's nominees to now lead the EEOC. Among other things, those nominees will now be responsible for rewriting those wellness rules.

I wanted to ask you, how should the EEOC set criteria for when participation in a wellness program is not voluntary? What advice would you give those five Members of the EEOC?

Ms. MATHIS. I think the most important thing for the EEOC to remember is that their job is to apply the ADA, and not to rewrite it. To try to conform it to another law that also applies at the same time, but did not overturn or modify the ADA.

There are many circumstances where two laws apply at the same time and one requires additional things beyond what the other requires. We have a lot of experience with applying multiple laws to the same set of circumstances.

They already have a framework that they had used for 16 years under the ADA. They used the same framework to analyze what is a voluntary question under GINA in their 2010 regulations, implementing a parallel provision of GINA allowing requests for an employee's genetic information as part of a voluntary wellness program.

I would just point out that that GINA regulation was done after the Affordable Care Act. They considered the two laws—and the fact that the Affordable Care Act had been passed with its provisions about wellness programs—and considered those consistent.

That framework was logical. It used the ordinary meaning of "voluntary," that you cannot require a person to answer or penalize a person for not answering a question.

That is consistent with the dictionary definition of "voluntary," which is, "Not impelled by outside influence or unconstrained by interference, or without valuable consideration." Having steep financial incentives, I think, is actually the dictionary definition of what is "not voluntary."

Having the same kind of framework, the same path that they charted for the 2010 GINA regulations to apply also to the ADA, which is how they interpreted the ADA before 2016 for many, many years to allow wellness programs to have incentives, but just not to incentivize or to have significant incentives for people turning over health information that is not job-related.

That, I think, would allow wellness programs to proceed, and develop, and use incentives in other ways, and use many other strate-

gies to engage people without eroding the civil rights of people with disabilities.

Senator MURRAY. Thank you very much.

The CHAIRMAN. Thank you, Senator Murray.

Senator Isakson.

STATEMENT OF SENATOR ISAKSON

Senator ISAKSON. Thank you, Senator Alexander.

Mr. Burd, if I remember correctly, the Safeway program had financial incentives for participants, by participation by employees. Is that right?

Mr. BURD. I am sorry. Could you repeat the question?

Senator ISAKSON. Did the Safeway program have financial incentives for the employees for participating in the wellness program?

Mr. BURD. Correct.

Senator ISAKSON. What have you found, in your work with wellness programs with companies, are the best financial incentives to put in place for your wellness program to induce more people to participate?

Mr. BURD. Yes. I think we had extraordinary participation, I think, even greater, Michael, than some of the numbers that you had. We were 85 percent voluntary for employees, 70 percent for spouses.

I am actually a big fan of both the 1996 HIPAA regulations—I thought they were well thought out—and the adjustments that were made with the Affordable Care Act. I thought those were equally well thought out.

I do not want the Committee to do is get the impression that it is all about incentives. Incentives are, I think, necessary, but by themselves, not sufficient.

In going back to something that David, you had said earlier. The "secret sauce" at Safeway was creating small support groups. We had thousands of groups that came together on their own, set goals and objectives, timeframes.

It might have been exercise goals. It might have been weight loss goals. We gave them the tools to accomplish that, the tools to attract one another. It really was a driving force in this along with CEO leadership.

I look at Government as being an enabler in this process, but I also think there is an opportunity for Government to lead.

I think others have been down here over the years and one opportunity to lead is I would love to see the Federal Government adopt programs like this for their own employees.

I actually offered to do this for Secretary Sebelius and the 80,000 people at HHS to do it for free. Unfortunately, that was about 30 days before she left office, and she was excited about that. It is not just about incentives. It is important that——

We employed 10,000 people with disabilities at Safeway out 185,000 people; 2,000 of them were part of this program. The HIPAA regs, when I say they are well thought out, they allow for, and frankly require, if the standard that you have set is judged to be too difficult that you adopt a different standard, and even provide a waiver.

In our experience—and I would be interested in what you have done at the Cleveland Clinic—about 3 to 4 percent would reach for and get either a waiver or an alternative standard.

While we wanted you to get below a 30 BMI, if you had a 45 BMI and you made 10 percent progress, we gave you the reward. At the end of the year when you measured, we gave you a reimbursement check and we enjoyed writing those checks. So it was all about encouraging wellness.

If you had co-morbidities, and your physician said, "Look. I would feel better going from 45 to 43." We would say, "Fine," and that is the standard. Then we would change that over time, and I am sure the Cleveland Clinic did something very similar.

Senator ISAKSON. Well, I appreciate the answer because being one who has had about every bad habit you could possibly have to be a core contributor to your health at one time or another, I know that what got me into health programs and wellness programs was the desire to change a habit. What kept me in them was the reward of that habit changing.

Mr. BURD. Yes.

Senator ISAKSON. I think you said something that is very important, and that is if you give the employee or the individual the measurements to show improvement and reinforce that along the way, you can change what the program is doing to induce them to be more healthy to an employee who is more healthy.

Because I know quitting smoking, changing your eating habits, exercising regularly, none of those things are easy. Everybody likes to talk about them and every New Year's, everybody practices them for about 2 days, but then they go away because they are hard to do. If you get reinforcement in a peer group——

Mr. BURD. Yes.

Senator ISAKSON [continuing]. In a positive way, you can really sustain the practice.

Mr. BURD. If I could just add one more thing, I think that I learned this a long time ago in business and it was helpful. I had 1,800 stores.

Rather than just study and hypothesize things, we just did it. We did it on scale and then we scaled it up.

For example, if I wanted to increase the sales of some product, I put it in the ad, I would reduce the price, and I would put it on an end cap.

At the end of the day, I did not care which of those three contributed most to that. I did all three of them every time I wanted to increase the sales by twentyfold. We struck upon something over time that worked, and it worked famously, and we had no issues with it.

If you do not know, the health statistics do not go to the H.R. department. They do not know what somebody's BMI is. They know there is a contribution to premium effect, but they really do not know what somebody passed and what somebody failed. We did not have any issues in the company and then we ultimately begin rolling that out to all the divisions. So our initial population was 40,000 Members.

Senator ISAKSON. Thank you, Mr. Chairman.

Let me just conclude with a compliment. Thank you, Dr. Roizen, for your reference to what the Finance Committee was doing. We have, in fact, now done at the Chronic Care Working Group bill has actually passed the Senate Finance Committee, and it has passed the Senate, and it s pending now in the Energy Committee in the house.

We are close to getting that 3 year effort done and I appreciate your reference to that.

Dr. ROIZEN. Let me make another comment. I think a couple of things he said deserve reemphasis.

One is there is an absolute firewall between the health plan and the company. They do not know why the premiums are where they are, or what is driving, or not driving it.

Second, for every person, they interact with their primary care physician in achieving those goals, those six goals plus two behaviors. It is the primary care physician, and they set a goal, and set a progress, and it is that relationship and that progress that determines their incentive.

It is a culture change. It is multiple programs that work. It is leadership as well. We also have a large buddy system that we set up that really does the support system.

There are a lot of things that I did not get into the nuts and bolts, but it is a lot of things that work.

The CHAIRMAN. Thank you, Senator Isakson.

Senator FRANKEN.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman, and to the Ranking Member, for holding this important hearing.

Before the hearing started, I spoke to all of you about housing. These wellness programs that the employer runs are very helpful, but what we are trying to do is to help people be healthy, and lower the costs of their healthcare in the long run.

Ms. Mathis, you pointed out research that shows a strong connection between a person's health and stable housing despite the fact that they are actually very often talked about as completely separate issues.

In Minnesota, Hennepin Health, an accountable care organization in the Twin Cities, saw the lack of stable housing was a major barrier to improving the health of their Members. So they decided to develop a program that paired healthcare, housing, and social services.

Just 1 year after participants in the program were placed in supportive housing, Hennepin Health saw significant reductions in participant hospitalizations, and psychiatric care, and imprisonment or going to jail.

The No. 1 cure for homelessness turns out to be a home. If you can wraparound supportive services, it yields amazing savings.

I brought this up to all of you. So Ms. Mathis and all of you, could you speak to how a focus on housing, particularly when it is paired with social supports, can lower healthcare costs and improve health outcomes?

Ms. MATHIS. I think that is absolutely right. That is, I think, a recognition that has become increasingly prevalent in state mental health service systems.

Maybe 20, 25 years ago, state mental health directors would have said, "We do not do housing. We are not in the business of housing. We do mental health." That has changed dramatically.

I think now most state mental health authorities would tell you, "We do housing because housing is a critical part of what we do." Housing supports, housing subsidies, housing assistance, housing locator assistance, all of that because all of these things—housing stability, work, all the social determinants of health—have been shown to have an enormous impact on people's health.

There have been many studies done. I think some of the interesting ones have been studies of people who are homeless versus people who are in supportive housing, similar twin studies of people in those two situations.

It costs us as much money to keep people homeless as it does to have them stably housed with services.

Senator FRANKEN. I want to hear from the others as well because you all seemed to respond when I brought this up.

Dr. ASCH. Senator Franken, thanks for the question and comment.

I fully agree. There is certainly a movement and a knowledge base called Housing First that recognizes the critical, central actually, fundamental importance of housing for those without it.

I would probably embed your question in a much larger set of issues that reflect the importance of the social determinants of health.

If you are a provider organization, a hospital or a health system, and you face patients who are chronically ill, and they are readmitted into your hospital multiple times for congestive heart failure, or lung disease, or some chronic illness, almost always the major determinant, in addition to their serious illness that brings them back to the hospital, is some form of social circumstance. Sometimes it is inadequate housing. Sometimes it is another form of social support.

At the time when hospitals were incentivized only to deliver healthcare, those considerations were, at least from a financial perspective, less relevant. Now hospitals and health systems are much more aware of their responsibility to be part of the solution to the social factors that affect health including housing. Some of the most progressive health systems are targeting housing directly along with other social determinants.

Those social determinants were always there and now we need to think about financial incentives that will allow, at the organizational level, the resources that we have in our society to address them.

The CHAIRMAN. I want to give the other two witnesses a chance to answer Senator Franken's question, but I want to stay pretty close to the time because we have votes at 11:45.

Dr. ROIZEN. Well, some would say, Senator Franken, you are a genius for bringing this up.

Senator FRANKEN. Thank you, thank you.

Senator BENNET. Only Senator Franken might say that.

[Laughter.]

Dr. ROIZEN. Because it is really one of the social determinants, and the social determinants are really important.

It is very hard to not have stress if you do not have a home. It is very hard to get adequate sleep without housing, and those are really key points in getting well, and in staying well, and in lowering the costs of medical care.

Mr. BURD. First of all, I wanted you to know that if he had not said you were a genius, I was ready to weigh in on that.

Senator FRANKEN. I was ready to do it as well.

[Laughter.]

Mr. BURD. My wife and I have been involved for several years in a philanthropic effort to provide housing to the homeless.

I am also involved in another philanthropic effort with a good friend where we take people who had been homeless and had the capability to learn a skill. They are taught the skill and then we find them a job, and they can succeed at that.

I think having a home is really important, and that social environment that surrounds it is also something that we create.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Franken.

We will go to Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Thanks, Mr. Chairman.

I want to thank the panel for being here and for your testimony on these important issues. I will direct, I think, most of my question time to both Dr. Asch and Ms. Mathis.

I wanted to say first, Dr. Asch, we are grateful you are here and grateful for the work you do at Penn. I guess you have done work at both the Perelman School of Medicine and at Wharton. I also want to thank you for the work you have done at the V.A. Medical Center in Philadelphia as well; critically important work.

I was not here for Senator Murray's questions, but I believe she asked a question about the penalties and the incentives.

Am I right about that?

Senator MURRAY. Yes.

Senator CASEY. I just wanted to make sure.

I guess my follow-up to that line of questioning would be with regard to you, Dr. Asch, that your research indicates the penalty incentives may not have had the effect on individual behaviors.

Both you and Dr. Roizen have indicated the importance of the many hours, I guess 5,000 hours, of waking activity when we are not interacting with the healthcare system.

Senator Murray indicated that some wellness plans use both penalties and rewards that can be as high as thousands of dollars a year.

We have heard that Dr. Roizen's program uses a 30 percent penalty, the limit that the EEOC has set when issued the rule last year.

My question is basically this.

Based upon your research, and other behavioral economic research, is it necessary to use such large penalties or rewards, and if not, what would you recommend such rewards or penalties to be?

Dr. ASCH. Well, thank you for your question, Senator Casey.

You have identified some critical issues at the interface of effectiveness and voluntariness right there.

A lot of employers are under, what I would consider to be, the mistaken impression that the way to make incentives effective is to make them larger and larger. That naturally leads to very large incentives, putting large amounts of money at risk, whether they are in the form of rewards or penalties.

We have heard, of course, that penalties are more off-putting than rewards, and actually sort of jacked up the concerns about the lack of voluntariness. I think it is potentially a mistake to think that way.

I actually think that that is old, outdated thinking that the only way to increase the potency of an incentive is to increase the size of an incentive.

Instead, we know from years of research now in behavioral economics that the way we design incentives probably has much more of an impact than the amount of an incentive.

You can imagine, for example, a $500 incentive that might be bundled into someone's paycheck. Well, if they are paid once a week, that is $10 a week. It looks much smaller then. It is put alongside all sorts of other elements in a paycheck. It may not even be seen. It is directly deposited.

You can imagine handing someone two crisp $100 dollar bills, a much smaller incentive, and have it be much more potent emotionally.

Another mistake that employers make often, but they do not need to make, is setting explicit targets for goals.

If you believe that your employees should be at a BMI of 25, which is, let us say, the upper limit of normal and you set that as the goal, that is a good way to make people whose BMI is 26 lose a few pounds. If your BMI is 40, that is a demoralizing goal.

What we care about is improvement, and pay for improvement programs are going to be far more effective for the people who we fundamentally need to help the most.

Both design elements with the structure of incentives, and design elements wit the targets for incentives can be improved by most employers. I am really optimistic that they can do that.

Senator CASEY. Thank you. I have more to pursue there, but I want to move to a separate line of questioning.

Ms. Mathis, I will start with you and I will invite others to answer as well.

The written testimony you have regarding balancing the personal rights of individuals, especially those with disabilities, while also pursuing the goal or encouraging wellness, your references to the privacy protections in the Americans with Disabilities Act, and other statutes, are critically appreciated, I think, at this time.

We know that October is National Disability Employment Awareness Month. As you have pointed out in your testimony, the employment rate for those with disabilities is very low in comparison to the general population.

Those with disabilities have the lowest rate of employment of any sector of our population and I am concerned that aggressive wellness programs could not only discriminate against a person with a disability, but also create a workplace climate that does not value people with disabilities.

Would you like to comment on that further?

Ms. MATHIS. Sure. I should just clarify that I think our primary concern about the large financial incentives is around those privacy protections.

Folks have talked about the incentives for outcomes. As Mr. Burd mentioned, there are built-in safeguards in the Affordable Care Act that, I think, do address that concern. That if you cannot meet a particular health outcome because of a disability, that you are supposed to get a reasonable alternative standard and there are regulations that sort of implement that.

I do not think that, certainly, we have not heard that there is a lot of, that that is a major concern anymore. I think that was addressed. Our concern is really much more around the privacy issues.

It is true that, I think, there are in many cases, the information will not go directly to an employer. Sometimes it will if the employer does directly run a wellness program. With small employers, obviously, it is not that hard to figure out who has what health condition that is identified in aggregate data.

Frankly, I think for many people with disabilities just having to turn over your sensitive, private health information, wherever it is going to go to, is concerning. It is not the way to build an environment of trust and a productive working environment.

People with disabilities have had, in many cases, many negative experiences in their lives stemming from the disclosure of those disabilities. It is very understandable why people react.

The CHAIRMAN. We need to try to stay within the time.

Ms. MATHIS. That is all I have to say.

Senator CASEY. Thanks very much.

I will do some follow-ups in writing.

Thank you.

The CHAIRMAN. Well, thank you, Senator Casey.

Senator Cassidy.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Dr. Asch, I am internist, as you, and although this is a health Committee, which is not Medicaid and Medicare, nonetheless I feel as if that which we are doing in the employer based setting has a fairly mature science.

As I think of my patients, whom I used to care for in the Louisiana public hospital system, the Medicaid patient or the uninsured, it is a bigger problem, if you will, some of these wellness issues. If you are in Philadelphia, you probably have a practice that is somewhat similar to mine.

How can we translate some of this, which we have been discussing for the workplace, into the Medicaid population, which statistically has a higher incidence of chronic disease, morbidity, et cetera, than the workplace?

Dr. ASCH. Well, thanks for the question, Senator Cassidy.

I think in most cases, these activities can translate. I do think that employers have a special role and a special trust connection with employees that may be not as high as the trust relationship people have with their doctor or with their hospital, but might be potentially higher than people have with their insurance carrier.

That trust is an important determinant of the success of the programs.

Senator CASSIDY. Now, let me ask you. Let me stop you for a second.

Dr. ASCH. Yes.

Senator CASSIDY. Because as I think of my Medicaid patient, there is a structure associated with an employer relationship and that structure allows them to give you 30 minutes off to go walk around the track if they have built one there.

Medicaid patients taking public transportation to their clinic appointment are cigarette smoking and there is nothing you can do on their Medicaid to incentivize them to stop smoking.

I guess I am not seeing that it is as easily translated—and, by the way, I am willing to open this up to anybody—because to me, it actually seems almost an apple and an orange.

Dr. ASCH. Well, so, we have run some programs that were employer-based that were designed to reduce the burden of tobacco on employees.

We did two studies, one at General Electric and one at CVS. Both were highly successful interventions, published in the "New England Journal of Medicine," and later adopted by those two companies. They reflected largely positive financial incentives delivered to workers to help them reduce the burden of tobacco.

There is no reason why programs like that could not also be introduced into the Medicaid population. They are incentive-based. They were successful. We can think of translating some of the science and the learning that we have developed from the employer setting——

Senator CASSIDY. Now, let me stop you because, again, you would be familiar with the structure of Medicaid, which if it is managed care, they contract with a provider to provide a service at a certain rate. If it is fee for service, you are just paying the bills as they come in. Typically, the patient is not directly impacted by this.

The Indiana experiment may be a little bit different, in which they prefunded health savings accounts. You could build in an award for that. So are you thinking in——

When you say build in an incentive, and again, I open this to anyone, how would you do that for the Medicaid as commonly structured under the ACA or any other program?

Dr. ASCH. Well, I am not sure I would know how to do it as it is commonly structured, but it does not mean that it could not be rethought, and that State Medicaid agencies might think about waivers, or the like, that would enable them to engage in those kinds of activities in order to achieve their mission.

I am not sure that they can do exactly what I just described under the rules as they are now, but under changed rules, they might be able to.

Senator CASSIDY. So the state could apply for a waiver asking for the flexibility to incentivize this sort of behavior, trying to translate

that which you have successfully shown works for an employer, but to do it for the Medicaid population.

Dr. ASCH. Yes.

Dr. ROIZEN. I totally agree with that.

Senator CASSIDY. Would you elaborate or accept just to agree?

Dr. ROIZEN. Well, I do not want to take too much time, but basically it is how do you get both programs that work, leadership and incentives, into the Medicaid program? Obviously Indiana, and even Ohio, are doing major efforts to do that, and seem to be succeeding.

Senator CASSIDY. So the prefunded Health Savings Accounts of the Indiana experiment really seem to be quite novel, but also quite effective. Folks who put in a little bit of money, got a lot more put into their HSA, and that seemed to modify behavior.

Is that what you are thinking of, along those lines, or something even more so?

Dr. ROIZEN. No, thinking about that along those lines and there are other ways of doing that as well, but that works.

Senator CASSIDY. What about things such as obesity? Cigarette smoking seems almost more tractable, if you will, than obesity, which is more intractable, it seems.

Dr. ROIZEN. Well, one of the things is, again, a culture program and multiple programs. So if one program does not work for everyone, we have, in fact, ten weight management programs at the Cleveland Clinic that 62 percent of participants have the choice of participating in. Weight Watchers may work for a group, and Curves may work for a group, and our own E-Coaching program works for a group.

When you get ten programs together, you can find programs that people can adopt, and in buddy systems, and in groups, if you will, participate and succeed.

Senator CASSIDY. So this might be a program employed by the Medicaid Managed Care program——

Dr. ROIZEN. Exactly.

Senator CASSIDY [continuing]. To lower their overall cost burden.

Dr. ROIZEN. Exactly.

Senator CASSIDY. I thank you.

I yield back.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman.

I would like to start by thanking you and the Ranking Member for your work, and your bipartisan effort to fix the healthcare system that we have.

On behalf of the people of Colorado, who have been waiting forever, it seems, for a bipartisan effort here, I want to express their gratitude to you for the work that you have done. My hope is that the Senate, and the house, and the President will work together to deal with an issue that confronts us right now with respect to the CSR's.

As you pointed out, Mr. Chairman, this is a cherished 6 percent of the people that are insured, but it is only 6 percent of the people that are insured.

This hearing really is about what we need to get after, which is the rising cost of healthcare in this country. I thank you for that as well. Whatever any of us can do to help your efforts, I hope you will let us know.

Dr. Roizen, could you describe briefly the bill that you mentioned in your testimony that Senator Portman and Senator Wyden are working on in the Finance Committee?

Dr. ROIZEN. It basically allows Medicare to incentivize and to do the same type of thing that we do for our employees: offer programs, offer incentives to get there, work with the primary care physicians to set the trajectory to improve and to get to the goals.

If you did that, if the Cleveland Clinic dollar number and participation number goes to Medicare—and remember, Medicare, 0.6 percent of Medicare achieves even four of the six behaviors and standards—if we did much more of that and got the 62 percent participation and 44-or-so percent success at getting to goal, the Government would save over $500 billion, maybe $1.2 trillion.

One of the things we have learned is putting stress management in first, even for the Medicare population, is really important at getting change.

We think this is an enormous opportunity, and Senators Portman and Wyden are working on this.

Senator BENNET. The reason that we are here today in this Committee is not about Medicare and Medicaid, but the 178 million Americans who are privately insured through their employer who could also benefit from the kind of incentive structures that you and Mr. Burd have put into place.

Dr. ROIZEN. Other parts of the program. It is not just incentive. It is some leadership. It is some cultural change. It is programs that help them. It literally changes the way they relate to their primary care physician.

There has to be some insurance rule changes that this Committee could work on to be able to allow the small, non-self-insured corporation to do this in a way that allows the employee to take the benefit as they go from one company to another. That allows the company to benefit after they have gotten the person healthier.

There need to be some rule changes, but those are minor and there would not be a dollar spent. Not a Federal dollar needs to be spent in advance or there is not an ask-for-money from the Federal Government at all. It just a rule change.

Senator BENNET. Mr. Burd, it is nice to see you again. I want to thank you for your leadership over many years in this area.

This is going to sound a little bit off base, but I just cannot resist because of what your job used to be. The question that I have for you is what you learned about what we are eating in this country in that job and how that is connected to health and how it is changing, if it is changing?

Mr. BURD. Well, I think increasingly the population is becoming more health conscious. I employee a number of Millennials these days and they are particularly careful about their nutrition.

When you run a supermarket chain, and you have 45,000 stock keeping units, you have all kinds of products in there. I am a big believer in free choice, but only if you also suffer consequences of that free choice.

All of us should be able to enjoy a French fry now and then, but I think those of us that are really into nutrition and fitness understand that if we indulge, we have another half hour to spend on the treadmill or walk after dinner.

One of the things that I wanted to mention about improving health, in particular when you work on BMI, I find that the Safeway number is extraordinary. The reason we started at 28 percent BMI is because all of the people, they are on their feet all day. We are not doing that here. We could have had a stand up meeting and gotten healthier.

The point is that when people just diet, and I think everybody here would agree, it does not work. The reason it does not work, if I lose 20 pounds and all I did was diet, for every pound I lost, I lost a quarter pound of muscle. Muscle is more efficient at burning calories.

When you finish that diet and you go back to your old eating habits or maybe even refined eating habits, you cannot eat as much in terms of calories because your burn rate has slowed down.

When I talk about an ecosystem at Safeway that we created, we stressed the importance of cardiovascular workouts. We stressed strength training. You can, at the age of 60, have the burn rate of somebody in their late 20's if you will do resistance training.

I contend it is the secret to weight maintenance. I would be shocked if you do not do resistance training.

Dr. ROIZEN. I do.

Mr. BURD. Okay. Thank you.

Senator BENNET. Thank you.

The CHAIRMAN. Thank you, Mr. Burd, and our next wellness hearing will be a stand up hearing. We will see what happens.

[Laughter.]

Mr. BURD. Very good. Even if we just stand up once during the hearing, it helps.

The CHAIRMAN. That is true.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman.

I want to see if I can just ask some more questions along this line.

We all know that the Affordable Care Act allows employers to offer financial incentives to their employees in order to encourage participation in these programs.

One thing the ACA does not do is eliminate the protections already in Federal law for employers, so that they cannot discriminate against their employees on the basis of genetic information, health status, or disability.

These protections were put in place by two very important pieces of legislation, the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act, or GINA.

This was a bipartisan bill. Senator Ted Kennedy worked with a number of folks on this Committee. Last year, Senator Enzi and I wrote and passed new legislation strengthening GINA protections so that personally identifiable genetic information collected through Federal research can never be made public.

In short, our Nation's nondiscrimination laws say that employers can collect sensitive medical information from their employees only if providing that information is voluntary. Meaning, the employee can decide to say no.

I just want to start by asking Ms. Mathis.

What types of personal health information do employers typically ask for as part of wellness programs?

Ms. MATHIS. I have seen these health risk assessments ask about all manner of health and medical information on a variety of levels of detail. I can give you some examples.

Specific cancer diagnoses such as breast cancer, cervical cancer, prostate cancer, weight, height, BMI, whether you are being treated for depression or bipolar disorder.

Specifics about your depression such as how many times you felt depressed in the last week, whether you had crying spells in the last week, how often you felt like people disliked you, how often you feel happy.

Whether you have been diagnosed with heart disease, stroke, high blood pressure, high cholesterol, angina, bronchitis, COPD, hepatitis B, obesity, high blood sugar, diabetes, or sexually transmitted diseases, to name a few.

Whether you are pregnant, whether you are trying to become pregnant, how old you were when you first became pregnant.

Those are some of the medical things that they ask about; lots of other questions about all sorts of other life habits.

Senator WARREN. So this is some really sensitive information, and it is supposed to be voluntary to hand it over.

Ms. MATHIS. That is right.

Senator WARREN. So let me ask about that.

Mr. Burd, when you were the CEO at Safeway, you set up a wellness program that you called completely voluntary. At the same time that families were charged $1,500 more in healthcare premiums if they did not participate in the program.

In fact, I think you said that you thought the penalty was not high enough. You lobbied hard to get the limits relaxed. The quote is, "Legislation needs to raise the Federal legal limits on the size of these penalties." I know that today you run a business that designs these kinds of penalties for other companies.

My question is when it costs an employee $1,500 or maybe more a year to get healthcare coverage because they do not want to have to share this kind of confidential medical information with their boss or because they cannot pass a biometric test, I do not understand how that connects, then, with the rules on discrimination. It sounds a lot like discrimination.

Mr. BURD. Well, we have been tested on that numerous times and were never accused of discrimination during the 10-year life of the program.

What you are referring to about my desire to raise those limitations that were in HIPAA, HIPAA originally in 1996 allowed a 20

percent premium differential based on behavior. If you look at something like smoking, the impact that smoking would have—— Toby Cosgrove used to say that smoking alone would cost about $3,000 more.

I did not say in my direct testimony, but I will say now that in our experience, about two-thirds, on average, two-thirds of that comes immediately back to the employees as a reward for making those standards.

It is not like they were charged $1,500. The $1,500 one, that would be if there was a spouse and an employee. So we think that we——I was questioned by the EEOC, I was questioned by the Labor Department. At the end of a 45 minute interview, I was told that I had properly followed the letter and the spirit of the law. We had not been accused of discrimination during that time period.

The person that was interviewing me actually wrote the HIPAA regs in 1996, or had a role in that, and said that if I ever opened up a Washington, DC office, they would love come to work for me.

Senator WARREN. Well, I am glad that is the case, and I am now over time. So I want to be respectful of the time here.

I have to say when you charge differentially, $1,500 or sometimes more, and that can happen because people do not want to reveal very sensitive, personal medical information. That is a penalty.

Paying a penalty may be legally all right, although as I understand it, the courts have now said that the EEOC is going to have to go back to the drawing board on the latest iteration of what the rules are.

We have not repealed our laws on discrimination and I just want to raise the issue that I think the question about what constitutes voluntary on this kind of sensitive information is one that we have also got to keep on the table, and maybe do some pushing in the other direction as well.

I apologize for going over, Mr. Chairman.

Dr. ROIZEN. May I make a quick comment?

This information is not revealed with a company. It is revealed with the health plan. There is an absolute firewall between the health plan and the company. In fact, we fire people who break that health plan because we have a tracking system. Every other health plan I know has a tracking system. If you break that firewall, you get fired.

Senator WARREN. Now, Dr. Roizen, all I want to say is what the law says is that the revealing of information has to be voluntary.

Dr. ROIZEN. It is, but it is voluntary with the health plan.

Senator WARREN. Telling people it will cost you $1,500 if you do not reveal very sensitive medical information, I think, stretches the bounds of what constitutes voluntary.

Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Warren.

Let me pursue that a little bit because my interest in this hearing, while there are several possibilities, is to take this remarkable consensus we have, and the Cleveland Clinic is certainly not the only one to suggest it. The Mayo Clinic says the same. Lots of people say it.

There are relatively few things that we could do that dramatically affect, about lifestyle, that dramatically affect chronic disease. Chronic disease is 84 percent of our healthcare costs and then we are talking about hundreds of billions of dollars to make a difference.

Then you go to the obvious point, and Mr. Burd has pointed out, it is not only wellness that you look at when you are looking at an employer plan, but insurance is clearly an obvious opportunity to take wellness and use employer insurance as a method of helping 178 million Americans have an opportunity to be healthier and save a lot of money for the country at the same time.

Mr. Burd and Dr. Roizen, how big a problem has it been for you in your employer plans to successfully deal with the concerns that Ms. Mathis has talked about, and that Senator Warren talked about, and that others have asked about? Is that a major impediment or do you think you can deal with those and treat employees fairly?

Dr. ROIZEN. We deal with it. We have 1,000 roughly exceptions requested by physicians who say, "This person, no matter what we do with them, cannot get to that normal." Those are accepted and they get a different plan.

In fact, in some of the extreme examples, someone just counts the amount of water they drink, bottles or glasses of water they drink a day to hit the health plan target and get the premium reduction.

The CHAIRMAN. So to get a premium reduction, you have the opportunity to say, "I need a different standard."

Dr. ROIZEN. The primary care physician.

The CHAIRMAN. Or, "I need an exception."

Dr. ROIZEN. That is exactly right.

The CHAIRMAN. That you, therefore, try to provide a fair process to meet that objective.

Ms. Mathis, does that work? I think I heard you say it probably did, that you were more concerned about the privacy.

Ms. MATHIS. Right. That is not the primary concern that we have. The primary concern is the incentive for disclosure of information.

The CHAIRMAN. Right.

Mr. Burd, what would your comment be on the kinds of impediment? Actually, you have talked some about it, but the reward or penalty for a healthier lifestyle.

Mr. BURD. Sure.

The CHAIRMAN. Has that been a problem for you?

Mr. BURD. I would say it has not been a problem and just consider the fact that 85 percent of the people did opt-in.

One of the reasons why I think we had such a high participation rate is I put enormous effort into communicating why this was a good idea. I reported my public earnings quarterly in a town hall meeting and in a broadcast, and I reported on the health of the organization.

People would catch me individually and ask me some questions about it, and when they really understood it, they quickly opted-in to the program because to Michael's point, there is a firewall there.

When you have a premium differential, you are just risk-adjusting the premium for individuals, but then giving them an opportunity to change their risk profile. We do that in life insurance, and we do that in automobile insurance, and behavior really matters.

What I would like the Committee to really focus on is that we have two practitioners here, maybe three, and there are very few people, I would say less than 1 percent of the companies in this Nation that have turned back obesity, that have improved the results on blood pressure, and cholesterol, and smoking.

These programs—and Michael and I have not had a chance to put them out in all of their glory—they work and nothing else has. I mean, a 21 percent obesity rate versus a Nation now close to 40.

The CHAIRMAN. Thank you, Mr. Burd. We are close to the time that we are going to be voting in a few minutes.

Dr. Asch, I would assume based on your behavioral research that if we wanted to incentivize United State Senators to pass an appropriation bill on time, that you would subtract from our salary instead of giving us a bonus.

Dr. ASCH. Maybe so, but I think you all deserve a raise.

The CHAIRMAN. Well, thank you for that.

[Laughter.]

Senator MURRAY. Take it under advisement.

The CHAIRMAN. Yes, take it under advisement.

Senator Murray, do you have additional questions?

Senator MURRAY. I do not. I know that Senator Franken, I think, had an additional question.

Senator FRANKEN. Yes.

Senator MURRAY. Correct.

I will just say—I know we are getting close to votes and we need to go—this has been a really good hearing, and we have a lot of work making sure we do this right.

I think it is critically important and, of course, balancing workers' civil rights and privacy. This has been a really important hearing and I appreciate everybody being here.

The CHAIRMAN. Thank you, Senator.

Senator Franken.

Senator FRANKEN. Thank you, again, both for this hearing.

It is very refreshing to be talking about keeping people healthy, and having a healthcare discussion that is not all about structures of insurance, although this has something to do with that.

I do want to talk about the National Diabetes Prevention program, which has been very successful. Before that, I just want to return one thing on the housing, which is on the opioid crisis.

I had a visit yesterday from Bois Forte, which is a band of Ojibwe in Minnesota. In Minnesota, we have just had an explosion in opioid use by, especially in Indian country. In Indian country, housing is an enormous issue.

As we go into this opioid, as it is being declared a crisis and an emergency, I would really like to see a pilot program where people who come back for treatment, especially in Indian country, have a place to go.

I was in Rochester, Minnesota a couple of breaks ago. We did an opioid roundtable and a woman whose daughter died, she had got-

ten treatment, got sober, but she went back with her old crowd, and she was gone.

We just need, I believe, to give people the opportunity to go to sober living facilities that are good sober living facilities. There is probably a distinction to be made here.

I would love to be able to pilot a program in Minnesota. I would love to do it in Minnesota where we actually, this is national, as bad as it could be in Minnesota in Indian country because there are housing shortages there where people coming back from rehab can go into a sober living setting.

They have secure housing, and that they have people that are in their same boat, and in recovery. Instead of a peer group, which is the other—a peer group that has a high drug use—they are having a peer group of people in their own fellowship.

That is just something I want to bring up.

Yes.

Mr. BURD. Senator, just to elaborate on what I said earlier, that is exactly what we do in this philanthropic effort. In other words, they have to be sober before they come in. They get tested while they are in that safe environment.

Senator FRANKEN. They have to be tested.

Mr. BURD. They get constantly reinforced. The program works. So if there is a way to expand that, I think it has great value.

Senator FRANKEN. Now on the National Diabetes Prevention program, this is something that Senator Lugar and I put in the ACA. Senator Grassley and Senator Collins have been very helpful in getting CMS to do, the Medicare.

What we learned is that this is a 16-week program and was piloted at the YMCA in St. Paul and in Indianapolis. This is by NIH and CDC. This is why it was me and Senator Lugar who put it in.

What it turned out that it is 16 weeks of both nutritional training and exercise. After 5 years, this is people who have high levels of sugar in their blood, glucose, and they were 58 percent less likely after 5 years to become diabetic, 70 percent less likely, if they were over sixty, which is why CMS is now in the process of implementing this.

So that any one in Medicare who wants to get the diabetes prevention program will be able to take this 16 week program and have it paid for by Medicare.

Can anyone speak to why this has been successful?

The CHAIRMAN. We have about 20 seconds.

Dr. ROIZEN. You get behavioral change, which is consistent. You also get buddy, it is a group, so you get buddy support. You get everything that a wellness program should be and you are targeting one of the specific high cost things; hemoglobin A1c or diabetes.

It is a great program.

Dr. ASCH. I agree. I think the diabetes prevention program is a great example of the importance of behavioral change.

The fact that this can be done without medication, without financial incentives speaks to a strong program and it has outcomes that you have mentioned are incredible, and they are persistent.

This, I think, is an incredibly optimistic light at the end of the tunnel there.

Senator FRANKEN. Thank you.

The CHAIRMAN. Thank you, Senator Franken.

Thanks to the witnesses for coming. I agree with Senator Murray, it has been a terrific hearing. We have learned a lot.

The hearing record will remain open for 10 days. Members may submit additional information within that time, if they would like.

The CHAIRMAN. The HELP Committee will meet again at 10 a.m. on Thursday, October 26 for a hearing entitled, "Exploring Free Speech on College Campuses."

Thank you for being here today.

The Committee will stand adjourned.

[Whereupon, at 11:43 a.m., the hearing was adjourned.]