National Association
of Health Underwriters
America's Benefits Specialists

December 1, 2009

Submitted through the Federal eRulemaking Portal

Office of Health Plan Standards
and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Attention: RIN 1210–AB27

Sir/Madam:

On behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 health insurance agents, brokers and consultants nationally, we are pleased to submit this response to the request for comments on the interim final rules implementing sections 101 through 103 of the Genetic Information Nondiscrimination Act of 2008 ("GINA"). The request was published by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") in the *Federal Register* on October 7, 2009.

The interim final rules implement provisions of GINA that prohibit group health plans from discriminating on the basis of genetic information. GINA provides that a group health plan may not (1) increase premiums or contributions for a group based on the genetic information of individuals in the group, (2) request or require an individual or family member to undergo a genetic test, or (3) request, require, or purchase genetic information prior to or in connection with enrollment or for underwriting purposes.

Background: As an association of professionals who help employers design the most effective health benefit plans for their employees, we know that American business owners are concerned that their health costs are soaring, hindering their ability to provide added value to their employees and their bottom line. Higher premiums, greater absenteeism and lost productivity have strained employers' ability to provide affordable coverage to their employees. Businesses are actively seeking means to encourage employees to take responsibility for their health choices in ways that will result in better health for the employees while also helping to reverse the trend of soaring medical care costs which stifle wage growth and workplace efficiency.

Congress has recognized the benefits of wellness/disease-management strategies to reduce costs and improve health in the current debate over health reform and have incorporated expanded wellness/disease management in their respective legislative proposals.

Our wellness programs: NAHU members have been committed to the use and expansion of wellness, prevention and disease-management programs for a number of years, and every day work with employers large and small to include these programs in employer-sponsored health benefit plan offerings. These programs address potential health problems of employees, often before they develop into more costly and deadly chronic diseases. These efforts to encourage and guide healthy behavior, which have become increasingly popular within our workforce, have helped to control our healthcare costs while improving quality of life for employees. For example, one 15-month study of 2,200 employees conducted in 2005 by My WellChoice, found a 29% reduction in medical claims and a 71% reduction in pharmaceutical costs. Improvements in health reported in the study included an eight percent reduction in cholesterol and a 3.23 point reduction in average BMI. Productivity gains were also up 23% with 77% fewer unscheduled days off.

A critical component of developing an effective employee wellness program and or disease-management program is the employee's completion of a Health Risk Assessment (HRA). The HRA is the gateway through which employees become aware of potential health risk factors and can be directed to appropriate disease-management and/ wellness program options. A key element of the HRA, sometimes the most important element, is a series of questions designed to gather family medical history. Based on the information elicited by the HRA, medical professionals can design a program to address the individual health needs of our employees, with special attention paid to diseases or conditions for which they are potentially vulnerable (as highlighted by the family medical history).

All individual information collected in the HRA of course remains confidential and is never shared with the employer, as required by the Health Insurance Portability and Accountability Act.

Impact of the regulation: Most employees need to be encouraged to complete a long, detailed HRA and to start to participate in a program of healthy living, and financial incentives provide a key motivational trigger. By allowing such incentives in the program, participation rates are well over 75%. The interim final regulation under Title I of GINA, by ruling the family medical history questions on the HRA fall under the definition of prohibited "underwriting purposes" would decimate our wellness programs by precluding our ability to provide a financial incentive to individuals who complete an HRA that requests family medical history and to provide rewards to employees for meeting certain health-related goals. If this regulation is allowed to be implemented, completion rates of HRAs will suffer significantly, and participation in wellness programs will plummet.

The regulation will also hamstring the ability of medical professionals to guide employees into disease-management programs because it would limit the ability to ask family-history questions in an HRA as part of a wellness program, even if there is no additional reward involved if these questions led to the placement of an individual in a disease-management program. The preamble explains that such questions would be for underwriting purposes, and therefore discriminatory. However, these rules are inconsistent, because they do not preclude other types of referrals to disease-management programs, which are well documented to reap great benefits to participants. They are also inconsistent because the rule later allows health plans to use genetic information with regard to the determination of medical appropriateness of a certain service for payment purposes, such as asking a plan participant for documentation of an increased risk for cancer in order to authorize payment for a screening test at an earlier age than would normally be covered.

The HRA is just one essential tool used by the health plans, not the employer, to target to conditions which can be influenced by patient monitoring and intervention. Disease management is a coordinated system of health care communications and information combined with doctor support designed to assist employees, and it not just cost-saver to the employer, it has many, many health benefits to the impacted

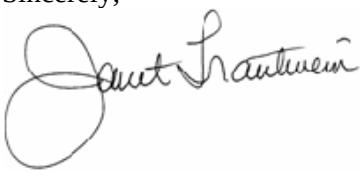
beneficiaries as well. We strongly believe than an exception should be made for disease-management purposes with regard to family history questions on an HRA.

Another concern we have with this proposed regulation is the effective date of December 7, 2009, and how it could cause many, many American employers to be unintentionally out of compliance. The majority of employer-sponsored health benefit plans are based on the calendar year, and many calendar-year plans have already distributed HRAs that include questions about family medical history as part of their open enrollment materials for the 2010 plan year. These plans may or may not have expectation of getting these documents back before January 1, 2010, and may have rewards already planned and promised to employees for completion to be distributed after the start of the new plan year.

In conclusion: Wellness, prevention and disease-management programs are one of the few avenues available to American employers to help control soaring healthcare costs. Moreover, these are programs that generally are met with enthusiasm by our employees, who are often relieved to be encouraged to lead a healthier lifestyle. Some employees are especially grateful to have completed an HRA and find out for the first time that they are at risk for certain diseases and that there are steps they can take to minimize their vulnerability. Making our tasks in this regard more difficult, by preventing the use of financial incentives to garner family medical history in an HRA, and also limiting the use of medical information gathered in an HRA with regard to disease-management participation are incomprehensible actions in view of the known benefits of these programs and the dire necessity of holding down medical costs and encouraging individuals to assume more active control of their health. The use of the HRA is completely voluntary, and while some participants do not reach their goals, the rewards work because they are based on positive experiences.

NAHU urges the inclusions of specific exceptions relative to family history questions on an HRA with regard to wellness and disease-management program referrals and participation, as well as revisions to effective date of this interim final rule so as to not impact the 2010 plan year. We appreciate this opportunity to provide comments and would be happy to further discuss our concerns with you.

Sincerely,



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