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Request for Information Regarding Sections 101 Through 104 of the Genetic Information Nondiscrimination Act of 2008

Comment On: IRS-2008-0103-0017
Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans

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Submitter Information

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Government Agency Type: Federal

General Comment

Please see attached letter

Attachments

IRS-2008-0103-0036.1: Comment on FR Doc # N/A

November 24, 2009

Hilda Solis, Secretary
U. S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Ms. Solis:

Coventry Health Care, Inc and its subsidiary health plans, fully support the goal of the Genetic Information Nondiscrimination Act (GINA) to prevent improper use of genetic information in hiring practices and in the provision and pricing of health insurance. However, elements of the Oct. 7, 2009, GINA interim final rule will create significant barriers to the use of health risk assessments and access to wellness and chronic disease management programs.

The departments of Health and Human Services, Labor and the Treasury must delay implementation and enforcement of the interim final rule and evaluate, through an interagency panel, the rule's potential impact on workplace health promotion programs.

The GINA regulation prohibits collecting family medical history as part of a health risk assessment that provides an incentive for completion. Regardless of the presence of an incentive, the regulation does not allow use of an HRA that collects family medical history to match individuals with appropriate chronic disease management services, which it defines as a benefit (i.e., an underwriting purpose).

Wellness programs (including wellness, prevention and disease management programs) are important opportunities to maintain health status, mitigate risk factors and support individuals managing chronic conditions. These programs are also important to restrain growing health care costs. Health risk assessments are a key tool in the implementation of wellness programs, and family medical history is a vital piece of the HRA.

Eliminating family medical history questions from an HRA linked to incentives significantly diminishes the effectiveness of the HRA. The alternative, removing incentives, drives down participation rates. Thus, individuals who could benefit from wellness and disease management services fall through the cracks, the prevalence of chronic conditions rises and employers experience increased health care costs and productivity losses.

Incentives can serve as powerful motivators: A $25 cash incentive can generally spur a 50 percent HRA participation rate compared with a 10 percent to 15 percent rate in programs without incentives.[i] A recent study shows that individuals who complete an HRA receive needed physician care, medication and cancer screenings more often than those who don't.[ii] Furthermore, research has shown a positive relationship between HRA participation rates and costs savings – an average of $212 per participant in one study.[iii]

GINA's restrictions on the collection of family medical history will result in fewer patients understanding their risk of disease and seeking appropriate, coordinated care from their physicians. Coventry supports the physician – patient relationship through our wellness and disease management programs, impeding awareness of genetic predisposition to disease will limit the effectiveness of the medical home and other models of care coordination for chronically ill patients.

Employers have embraced workplace wellness: Two-thirds offer formal health and wellness programs, and about a third of those without programs plan to add them, many within six to 12 months.[vii] Employers successfully use incentives to drive employee participation. GINA would curtail this practice. Furthermore, HRAs offer employers a more effective means than claims data review alone to identify high-risk plan members, improve care quality and lower costs. GINA would limit HRA effectiveness with its prohibition on family medical history questions. HRAs provide a key point of entry to those health care services of particular value to chronically ill employees and those at risk of disease.

GINA does not offer practical options, the first two: removing questions about family medical history from the HRA, which greatly diminishes its effectiveness; or ending incentives, which drives down participation rates. A third option, establishing two health risk assessments – one with questions about family medical history and one without – adds a burdensome layer of complexity, inconveniences employees and increases health care costs. Additionally, given this compressed timeframe and fears about running afoul of the regulations, employers might restrict wellness and disease management activities even beyond what GINA requires, further harming these programs.

The GINA regulations will hamper our health plans ability to identify and engage plan members early in the progression of disease, when interventions are most effective, who could benefit most from wellness and disease management programs.

In light of Coventry Health Care, Inc.'s concerns with the implementation of the regulations under Title I, and anticipated regulation under Title II, impacts to existing workplace wellness programs, employer and health plan sponsored wellness programs; we are requesting the departments of Health and Human Services, Labor and the Treasury delay implementation and enforcement of the interim final rule. Please consider evaluation, through an interagency panel, the rule's potential impact on workplace health promotion programs.

Thank you for your meaningful review of this request.

Sincerely,

Deanna Marcelo, RN MS

Deanna Marcelo, RN MS
Director, Corporate Quality Improvement

c: Timothy Geithner, Secretary, U. S. Department of Treasury
Kathleen Sebelius, Secretary, U. S. Department of Health and Human Services
Stuart J. Ishimaru, Acting Chairman, U. S. Equal Employment Opportunity Commission
Robert Kocher, M.D., Special Assistant to the President, National Economic Council, The White House
Ezekiel Emanuel, M.D., Special Advisor for Health Policy, Office of the Director, Office of Management and Budget

[i] Wellness Councils of America. Absolute Advantage, 2006;6(1).
[ii] Health Aff (Millwood). 2009;28(5):1532-40; 10.1377
[iii] Serxner, Seth A. PhD, MPH; Gold, Daniel B. PhD; Grossmeier, Jessica J. MPH; Anderson, David R. PhD. The Relationship Between Health Promotion Program Participation and Medical Costs: A Dose Response J Occup Environ Med. 2003;45:1196-200.