GroupHealth

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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
United States Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20219

Attention: RIN 1210-AB27

I am writing to convey Group Health Cooperative's concern regarding certain aspects of the Interim Final Rules interpreting Sections 101 through 104 of Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA). The rules as written will have a detrimental effect on the ability of health plans to contribute to improvements and reduce the cost of health care.

Group Health Cooperative is one of America's oldest and largest consumer-governed health care organizations. Founded in 1947, the organization is governed by its members – nearly 640,000 covered lives across Washington state and north Idaho. We are a national leader in integrated care, and an important voice for health care reform. Group Health is heralded as a model for health care that focuses on and delivers better health. We are proud of our innovations such as the use of electronic medical records; online patient services such as secure messaging with health care providers and online prescription refills; and the provision of team-based health care through a medical home. Additionally, Group Health has a long-standing focus on prevention, early screening, and evidence-based medicine.

Congress enacted Title I of GINA to prevent group health plans and health insurers from charging higher premiums or denying benefits on the basis of genetic information; requiring or requesting individuals to undergo genetic testing; and requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or for underwriting purposes. Group Health unreservedly supports these objectives, which are consistent with its long-standing practices.

However, we believe that the Interim Final Rules fundamentally misinterpret GINA by defining "underwriting purposes" to include offers of plan-based financial incentives that are designed to encourage enrollees to provide clinically relevant information, including family medical history, through health risk assessments (HRAs). These objectives – improving care while lowering costs – are at the foundation of ongoing Congressional and Administration health reform efforts. To support these common goals, we urge you to reconsider the interpretation contained in the Interim Final Rules.

HRAs are a relatively recent innovation that can enhance individuals' ability to manage their health, while lowering the cost of their medical care. HRAs generally use clinically relevant information supplied by the enrollee; this process results in the immediate generation of a health risk assessment report. Using that report, the enrollee can become better informed about the status of his or her health, as well as his or her unique health risks, and can take positive action towards better health—whether that involves eating more healthfully, exercising more, or making an overdue appointment for preventive care.

Within Group Health's integrated system, in which the financing and delivery of care are linked, a HRA may be used to further advantage the patient in that it can derive valuable assessment information via expertly developed health risk algorithms and is used to populate our members' electronic health records with clinical information that is relevant and immediately accessible to the patient's health care team for treatment purposes.

Family medical history is a powerful tool for predicting the risk of many health concerns, such as heart disease, colorectal cancer, breast and ovarian cancer, osteoporosis and diabetes. HRAs such as Group Health's are an efficient, effective mechanism for collecting family history and transmitting it seamlessly into patients' medical records. They are invaluable tools that advance patient, provider, and policy goals of improving health and preventing disease.

However, the mere ability to solicit family history information is of little value unless enrollees are motivated to provide it. In this regard, experience has taught us that incentives work. In the health plan we offer our own employees, a modest incentive – a flat premium discount that was equivalent to between 1.7% and 9% of the total premium cost – succeeded in driving the HRA completion rate from approximately 20% to over 90% in just one year. By classifying the provision of such incentives as an "underwriting *purpose*," the Interim Final Rules confuse a health plan's *means* with its *end,* or purpose. The prohibition of incentives in this context will severely restrict us, as a practical matter, from using HRAs to obtain important clinical information, and will therefore affect our ability to provide the best medical care and preventive screening.

Finally, we believe that the Interim Final Rules run counter not only to the existing HIPAA Nondiscrimination and Wellness Programs regulations (which expressly permit premium and cost-sharing incentives of up to 20 percent of the cost of coverage in connection with wellness programs), but also to the Administration's ability to achieve stated health care reform goals of improved quality and reduced costs.

We are deeply concerned that the Interim Final Rules, if left unchanged, will significantly encumber efforts by Group Health Cooperative and many other organizations to improve the health of individuals and populations and provide patients the best medical care possible while reducing costs. We urge the Departments of Labor, Health and Human Services and the Treasury to rescind or suspend implementation of the Interim Final Rules, obtain additional feedback from key stakeholders, and devise an alternative approach that recognizes the important role that health risk assessments and associated incentives play in support of important national policy objectives.

Thank you for your consideration of these concerns.

Sincerely,

Scott Armstrong
President and Chief Executive Officer

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