Baum, Beth - EBSA

From: Anne Lennan [anne@spbatpa.org]
Sent: Tuesday, January 05, 2010 2:09 PM
To: EBSA, E-OHPSCA - EBSA
Subject: Comments on RIN 1210-AB27

January 4, 2010
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

Dear Regulatory Drafters:

These comments on the Interim Final Rules implementing sections 101 through 103 of the Genetic Information Nondiscrimination Act of 2008 (GINA) are submitted on behalf of the Society of Professional Benefit Administrators (SPBA).

SPBA is the national association of Third Party Administration (TPA) firms that are hired by employers and employee benefit plans to provide outside professional management of their employee benefit plans. It is estimated that 55% of US workers in non-federal health coverage are in plans administered by some form of TPA. The clients of TPA firms include every size and format of employment, including large and small employers, state/county/city plans, union, non-union, collectively bargained multiemployer plans, as well as plans representing religious entities. Most of these clients are ERISA self-funded plans and sponsors, but our member TPAs also provide services to other types of plans, such as insured, HMO, etc. Our comments reflect this wider perspective.

First, we must express our extreme disappointment with the failure of the Interim Final Rules to permit group health plans to provide rewards for completing health risk assessments (HRAs) that request family medical history. We do not believe Congress intended the GINA statute to be interpreted to limit severely the ability of employers and plan sponsors to help plan participants stay healthy.

The Departments acknowledge that the prohibition in the Interim Final Rules on offering incentives may lead to a cost associated with the foregone benefits of identifying disease risks early and preventing their onset. The Departments invited public comments on this issue and requested evidence-based estimates of these forgone benefits.

We are not aware of evidence-based estimates of what these forgone benefits may be at this time. The lack of studies in this area can be attributed to the fact that employers and plan sponsors have not offered wellness program incentives for long enough periods of time that would yield data on long-term disease prevention. However, the impact of incentives on participation rates in HRAs is clear. Our Third Party Administrator members tell us that strong incentives are critical to high participation rates in wellness programs and health risk assessments. Without a financial incentive, participation in wellness programs typically drops by more than 50%, according to reports from our members.

Family medical history is a key component in administering wellness programs, allowing high-risk individuals to be identified and assisting them in obtaining appropriate interventions. All of our members have given SPBA countless examples of individuals who have been on the brink of serious

medical incidents when the information gathered through a health risk assessment led to the uncovering of the potential risk and subsequent mitigation. Health risk assessments save lives.

Our disappointment with the Interim Final Rule was compounded when we read the confusing examples involving disease management programs. These examples suggest that even if the health risk assessment is completed after enrollment and there is no reward offered, family medical history should not be requested if the answers lead to a participant's enrollment in a disease management program. We urge the Departments to rethink and rework these confusing examples.

If the Departments' intent is to eliminate the collection of family medical history for purposes of a disease management program when the health risk assessment occurs after enrollment and there is no reward or penalty offered, we caution against this interpretation. Employers and plan sponsors have tried every available tool in an attempt to reduce the rising cost of their health care bill, including increasing deductibles, co-payments, employee cost-sharing of premiums and a host of other strategies. These strategies have not been able to stem the upward trend. The focus now is to address one of the root causes of high health care costs: unhealthy plan participants. The family medical history component is crucial to evaluating an individual's health and running an effective disease management program.

Whichever the interpretation the Departments' select with respect to disease management programs, we request that informal guidance in the form of questions and answers be posted as soon as possible on their respective websites.

Health Care Coaches

Disease management programs typically offer coaching services performed by health care professionals who engage individuals in a discussion about their health and lifestyle. These coaches often inquire about family medical history with the intent of helping individuals better understand their risk factors. Do the Interim Final Rules limit this common practice?

If the Departments' interpretation is to limit the types of questions disease management coaches may ask participants, we urge the Departments' to reconsider. The Departments' have recognized the importance of allowing a health care professional to recommend a genetic test. We urge the Departments' to recognize the importance of allowing health care professionals operating under a disease management program to inquire about family medical history and offer recommendations based on that knowledge.

Dependent HRAs – Employers and plan sponsors are extending their wellness initiatives to the dependents of employees. May family medical history of the employee (parent) be used to coach a dependent child?

Clarification Requested on Rewards Outside the Plan

While incentives for completing health risk assessments that involve deductibles and cost-sharing arrangements under the plan had been growing in popularity until the publication of the Interim Final Rule, other strategies are also used, such as cash payments, gift cards, entertainment tickets, or various personal-use items. Please clarify whether incentives, designed to encourage individuals to provide family medical history as a part of a health risk assessment, provided outside the plan that do not involve any cost-sharing plan arrangements are prohibited by the Interim Final Rules.

Thank you for considering our comments.

Regards,

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