ERIC

The ERISA Industry Committee

January 25, 2013

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: Wellness Programs

Ladies and Gentlemen:

The ERISA Industry Committee ("ERIC") is pleased to submit this response to the request for comments on proposed rulemaking regarding nondiscriminatory wellness programs in group health coverage. The request was published by the Departments of Labor, Health and Human Services, and Treasury (collectively, the "Departments") in the *Federal Register* on November 26, 2012.

These proposed regulations, pursuant to standards set out in the Patient Protection and Affordable Care Act ("ACA"), would implement an increase in the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health coverage) from 20% to 30% of the cost of coverage. The proposed regulations would further increase the maximum permissible reward to 50% for wellness programs designed to prevent or reduce tobacco use. These regulations also amend the reasonable design and reasonable alternative requirements for health-contingent programs.

ERIC's Interest in the Proposed Rulemaking

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, incentive and welfare benefit plans of America's largest employers. ERIC's members sponsor group health plans that provide comprehensive health benefits directly to millions of active and retired employees and their families. ERIC has a strong interest in proposals that affect its members' ability to deliver high-quality, cost-effective benefits.

Over time, it has become more and more difficult for ERIC members to continue to deliver high quality health benefits due to spiraling costs. In addition, the expense and administrative complexity of implementing the numerous – and exceedingly complicated – rules of the ACA have made this task even more challenging. It is important to remember that every dollar spent to conform to the new rules is a dollar that is no longer available to pay for health care benefits.[1]

[1] Towers Watson, Health Care Reform*:* Looming Fears Mask Unprecedented Employer Opportunities to Mitigate Costs, Risks and Reset Total Reward, 4 (May 2010), *available at* http://www.towerswatson.com/assets/pdf/1935/Post-HCR_Flash_survey_bulletin_5_25_10(1).pdf (in response to increases in health care costs, 88% of employers plan to pass on costs to employees and 74% plan to reduce health benefits).

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Given these challenges, the promotion of wellness for each and every American worker – and his or her family – has become of paramount importance, as it is one of the few efforts that demonstrably can reduce future health care costs while simultaneously providing tangible benefits to employees and employers alike. The importance of wellness initiatives is a rare point of agreement for all, from Democrats[2] to Republicans,[3] and from academics[4] to for-profit businesses.[5]

Employers benefit when effective workplace wellness programs improve the health of their workforce. Worksite productivity is diminished when employees are ill and unable to perform their jobs, either because they are too sick to work or because illness has hampered their productivity.[6] A healthy employee is one who can concentrate on the task at hand, not distracted by personal and family health problems.

For employees, participation in wellness programs can offer the immediate rewards of better health and a higher quality of life.[7] Participating employees also face a brighter future when wellness programs uncover personal histories indicating predisposition towards a particular illness that – with appropriate help and guidance – may be avoided or limited in effect.

The incentives offered in health-contingent wellness programs can further benefit employees who seize the opportunity to improve their health. The economics of health insurance risk pooling means that the poor lifestyle choices of some employees can adversely affect the premium costs of coworkers in the same health plan. For employees with a poor health history, wellness programs can promote awareness of a healthier lifestyle and provide them with the means and encouragement to take steps toward its achievement. At the same time, these programs can inspire and reinforce the continuing efforts and accomplishments of those who are already on track with a healthy lifestyle.

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[2] *Addressing Insurance Market Reform in National Health Reform (Roundtable Discussion): Hearing Before the S. Comm. on Health, Education, Labor & Pensions*, 111th Cong. 77 (2009) (statement of Sen. Tom Harkin, Member, S. Comm. on Health, Education, Labor & Pensions : "Right now, only 7 percent of employers offer wellness and prevention programs to their employees. . . . So we have a long way to go to get in business.").

[3] *Healthcare Reform Roundtable (Part 2): Hearing Before the S. Comm. on Health, Education, Labor & Pensions*, 111th Cong. 97 (2009) (statement of Sen. Lamar Alexander, Member, S. Comm. on Health, Education, Labor & Pensions: "one area where [the committee has] great consensus is the importance of prevention and wellness."); *Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs: Hearing before the H. Comm. on Ways & Means*, 111th Cong. 9 (statement of Rep. Dave Camp, Member, H. Comm. on Ways & Means).

[4] Katherine Baicker et al., *Workplace Wellness Programs can Generate Savings*, 29 Health Affairs 304, 308 (Feb. 2010), *available at* http://nrs.harvard.edu/urn-3:HUL.InstRepos:5345879.

[5] The Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits: 2012 Annual Survey, 179, 187 (November 2012), *available at* http://ehbs.kff.org/pdf/2012/8345.pdf (73% of employers offering wellness programs believe the programs improve employee health).

[6] Ross DeVol & Armen Bedroussian, An Unhealthy America 131-32 (Milken Institute Oct. 2007) (estimating $1B annually in lost employee productivity due to reduced performance and missed workdays related to chronic disease), *available at* http://www.milkeninstitute.org/pdf/chronic_disease_report.pdf.

[7] Vicki S. Conn et al., *Meta-Analysis of Workplace Physical Activity Interventions*, 37 Am. J. Preventative Med. 330, 333-34 (2009) (surveying wellness program studies and finding statistically significant improvement in fitness, diabetes risk and participant-reported quality of life and mood for certain studies), *available at* http://www.ajpmonline.org/article/S0749-3797(09)00413-9/.

Increasing participation in wellness programs is a top priority for employers.[8] To this end, employers are seeking to change workplace cultures, increase employee awareness and improve performance. Employers are also turning to another critical tool for increasing employee achievement of wellness objectives: economic incentives.[9]

Current research shows that rewarding wellness improvements is an effective strategy,[10] and that the effectiveness of incentive payments may increase along with the reward size.[11] As more is learned about best practices for optimizing standards and incentives for health-contingent offerings,[12] the import of these programs will grow.

ERIC members believe that continued expansion of, and research on, incentive-based wellness programs will prove mutually beneficial to employers and their employees. We strongly encourage the Departments to continue to ensure that the wellness regulatory environment provides sufficient flexibility to permit this growth and optimization process to develop.

I. Comments on the Proposed Regulations

ERIC appreciates and strongly supports the Departments' efforts to promote workplace wellness program expansion while balancing the desires of individuals who are not able to participate fully in these programs. To encourage the development of more effective wellness programs that meet these objectives, ERIC suggests that the following five changes be incorporated into the final rules:

- Permit plans to use the reasonable valuation method best suited for a program, including actuarial valuation for programs with variable-value rewards;
- Confirm that the costs of services or goods provided to, or utilized by, plan participants in a health-contingent program are not included in the value of the reward;
- Accelerate applicability of the increased reward limits for all plans;
- Strengthen disease management programs by resolving all conflicts between the reasonable design and reasonable alternative requirements and "benign discrimination"; and
- Retain a workable and effective definition of "reasonable design". .

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[8] Aon Hewitt, 2012 Health Care Survey, 8 (2012), *available at* http://www.aon.com/attachments/human-capital-consulting/2012_Health_Care_Survey_final.pdf (70% of employers want to raise wellness program utilization).

[9] HERO, ACOEM, ACS, American Diabetes Association & AHA, *Guidance for a Reasonably Designed, Employer-Sponsored Wellness Program Using Outcomes-Based Incentives*, 54 J. Occupational & Envtl. Med. 889, 889 (July 2012), *available at* http://journals.lww.com/joem/Abstract/2012/07000; *see also* Aon Hewitt, *supra* note 6, at 33 (from 2011 to 2012, use of financial incentives increased from increase 17% to 54% in disease management programs and from 37% to 59% in health improvement programs).

[10] Soeren Mattke et al., RAND Corporation, A Review of Workplace Wellness Programs, 32 (July 2012); *see also* Employee Benefit Research Institute, Issue Brief No. 379: Findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey, 11 (Dec. 2012), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-2012_No379_CEHCS2.pdf ("[B]etween about 60 percent and 80 percent of participants said they would participate in wellness programs if there was some type of financial incentive to do so.").

[11] Dariush Mozaffarian et al, *Population Approaches to Improve Diet, Physical Activity, and Smoking Habits: A Scientific Statement from the AHA*, 126 Circulation 1515, 1530-31 (Aug., 2012), *available at* http://circ.ahajournals.org/content/126/12/1514 (incentives led to greater participation and completion rates in smoking cessation and weight loss programs, with larger incentives leading to larger better outcomes.").

[12] HERO et al., *supra* note 9, at 894-95; Mattke et al., *supra* note 10, at 32.

In addition, ERIC commends a number of changes introduced by the Departments in these proposed regulations. In particular, the revised form notice to participants regarding the availability of reasonable alternatives deserves to be incorporated into the final regulations.

A. Clarify that any reasonable method, including actuarial valuation, may be used to determine the value of wellness rewards that cannot be calculated in advance

The Departments have requested comments on how to apply the reward limits under subsection (f)(3)(ii) to wellness rewards that have an indeterminable value when first offered.[13] Existing regulations do not address the process for administering health-contingent programs that reward participants with waivers of copayments or deductibles. ERIC proposes a flexible valuation standard that avoids imposing unnecessary administrative burdens while facilitating innovative variable value rewards.

While the use of variable value rewards is not currently widespread, perhaps because of uncertainty over their regulatory treatment, the ability to tie an incentive to a participant's specific health challenge can enhance his or her performance and attainment of the associated wellness objective. For example, a comprehensive diabetes treatment program could reward participants that meet a BMI improvement threshold with a waiver of copayments on all diabetes treatment supplies and medication. Participants in such a plan gain two important advantages: first, achievement of the specific wellness objective (in this case, a reduced BMI) leads to an improved health outlook; second, access to lower cost diabetes supplies and medications, promotes adherence to prescribed diabetes management programs.

Under the current and proposed regulations, administration of such a diabetes management program is unnecessarily complicated. First, administrators must communicate the inconsistent, and potentially self-defeating, message that while participants are encouraged to take advantage of copayment relief, their benefits could stop abruptly if utilized frequently. Second, throughout the program, the administrator would need to track invoices from various service providers to ascertain the current cash value of the copayment waiver and avoid a breach of the 30% reward limit. Endorsement of actuarial valuation of rewards in the final regulations would eliminate these uncertainties.

No one-size-fits-all method exists for valuing all of the types of rewards that a comprehensive plan might offer. In any given plan year, actuarial valuation will prove indispensable for some programs and cost prohibitive for others. Accordingly, ERIC urges the Departments to allow plans to use the valuation methodology most appropriate for the specific reward offered, even if this requires use of different methodologies for different programs in the same plan year.

B. Confirm that the services and goods provided to participants as part of their pursuit of a health-contingent program reward are not a part of the reward.

Simply participating in a health-contingent wellness program is often valuable to participants, and costly to the plan, regardless of the participant's ultimate success in earning a reward. ERIC seeks confirmation in the final regulations that for purposes of subsection (f)(3)(ii), the term "reward" is limited to benefits provided to the participant after completing the program objective and does not include the value of participating in the program.

All participants in any given health-contingent wellness program are eligible to earn the same reward. To earn that reward, different participants may engage in different activities based on the reasonable alternatives suited to their medical conditions. Including the costs of these different activities in the calculation of the 30% and 50% reward limits would lead to inconsistent treatment of participants within a single program. Only the final good, service, voucher, discount, relief from surcharge, or other benefit awarded to participants upon

[13] *See* preamble, 77 Fed. Reg. at 70624.

completion of a wellness program should be treated as the reward.

Defining reward in this manner is consistent with examples throughout the current and proposed regulations. These examples describe health-contingent programs that offer tobacco cessation programs,[14] health risk assessments ("HRAs"),[15] and other valuable health-improvement services.

To enable effective health-contingent wellness programs to be administered uniformly, ERIC urges the Departments to confirm the common sense understanding that the size of a reward under subsection (f)(3)(ii) is limited to benefits earned by participants upon completion of a health-contingent program, rather than the value of the program or the value of goods and services provided as part of participation in the program.

C. Enable plans, especially non-calendar year plans, to utilize the increased reward limits immediately

The Departments requested comments on the proposal that these regulations apply for new plan years beginning on or after January 1, 2014.[16] The increased reward limit of subsection (f)(3)(ii)(A) is unique among the proposed rule changes in that it can be immediately utilized by employers to drive wellness efforts forward. Thus, ERIC recommends that the new reward limit take effect immediately for all plans instead of being tied to commencement of a new plan year.

An immediate effective date would allow plans that want to leverage a higher reward limit right away to either increase rewards for underutilized existing programs or initiate promising new programs. This would benefit both employers and employees.

Earlier in the wellness program rulemaking process, the Departments signaled their intent "to propose regulations that use existing regulatory authority under HIPAA to raise the percentage for the maximum reward that can be provided under a health-contingent wellness program to 30 percent before the year 2014."[17] An immediate effective date, and even a retroactive January 1, 2013 effective date, would be consistent with this previously-expressed intent of the Departments.

Employers with non-calendar year plans will be especially disadvantaged if the reward limit increases are delayed until new post-January 1, 2014 plan years. Under the Departments' proposed effective date, many of these plans would lose out on half or more of the 2014 reward increase promised by the ACA.

The Departments recognize that while the ACA raises reward limits for 2014, they already possess the authority to raise limits under the Health Insurance Portability and Accountability Act ("HIPAA").[18] Thus, we urge an increase in reward limits as soon as possible, but certainly no later than January 1, 2014, for all plans.

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[14] *See e.g.*, Prop. Reg. 54.9802-1(f)(3)(ii)(B) Example 2

[15] *See e.g.*, Prop. Reg. 54.9802-1(f)(3)(ii)(B) Example 4

[16] *See* preamble, 77 Fed. Reg. at 70625.

[17] DOL, Treasury & HHS, FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation (Dec. 22, 2010), *available at* http://www.dol.gov/ebsa/faqs/faq-aca5.html.

[18] *See* preamble, 77 Fed. Reg. at 70622.

D. Confirm that specific wellness programs may limit eligibility and rewards to targeted groups of individuals with adverse health factors

ERIC urges that the Departments clarify HIPAA's anti-discrimination protections, and the new proposed regulatory guidance, to ensure that they do not constrain wellness programs designed to assist populations with adverse health factors.

The final 2006 HIPAA regulations recognize that the law targets discrimination *against* persons who have adverse health factors, not efforts that disproportionately benefit persons with adverse health factors. The regulations explain that "[n]othing in this section prevents a group health plan" from easing plan eligibility or reducing plan premiums and contributions if the extra benefit "is based on an adverse health factor, such as disability."[19]

Pursuant to this authority, the Department of Labor has indicated in Field Assistance Bulletin (FAB) 2008-02 that subsection (g) of the 2006 regulations authorizes reduced deductibles based on benign discrimination.[20] The same guidance explains, however, that subsection (g) alone cannot authorize such an outcome contingent on both a participant's adverse health factor and that participant's satisfaction of a health-based objective. Instead, the program must satisfy the health-contingent wellness program regulations under subsection (f).

Benign discrimination not only benefits individuals most in need of extra medical attention and resources, it may also be among the most effective approaches to reducing future health care costs. A principal culprit in our nation's soaring health care costs is treatment of chronic conditions triggered by avoidable conditions including obesity[21] and smoking.[22] Given the stakes involved, plans may wish to make larger per capita investments in rejuvenating the health of these populations than would be feasible on a plan-wide basis. Furthermore, wellness programs that target high-risk populations are more consistently effective than broad-based programs.[23]

The uniform availability requirement under subsection (f)(3)(iii) of the proposed regulations requires health-contingent wellness programs to offer a reasonable alternative standard (or waiver of the standard) to any individual for whom it is unreasonably difficult due to a medical condition to satisfy the standard or for whom it is medically inadvisable to attempt to satisfy the standard. The reasonable design requirement under subsection (f)(3)(iv) permits plans to base a reward on the results of a health-factor test, measurement or screening, but only if individuals who do not meet the initial standard are offered a different, reasonable means of qualifying for the same reward.

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[19] DOL Reg. § 2590.702(g)(1)-(2); Treas. Reg. § 54-9802-1(g)(1)-2).

[20] DOL Field Assistance Bulletin No. 2008-02 (Feb. 14, 2008), *available at* http://www.dol.gov/ebsa/regs/fab2008-2.html.

[21] Joanna C. Parks et al., The Marginal External Cost of Obesity in the United States, 1 (Agricultural & Applied Economics Association Select Paper for July 2012 Meeting) (surveying studies indicating that obesity related to 37% of increase in health expenditures from 1998 and 2006 and will further increase $66B by 2030), *available at* http://ageconsearch.umn.edu/bitstream/125128/2/ParksEtAlRev.pdf.

[22] *See* James M. Lightwood et al., *Effect of the California Tobacco Control Program on Personal Health Care Expenditures*, 5 PLoS Medicine 1214, 1218 (Aug. 2008) (finding reduction in California smoking saved $86B over 14 year period), *available at* http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0050178.

[23] Iris Groeneveld et al., *Lifesyle-focused Interventions at the Workplace to Reduce the Risk of Cardiovascular Disease – A Systematic Review*, 36 Scandinavian J. Work Envtl. & Health 202, 211 (surveying wellness programs and finding that they effectively reduced body weight for high-risk population, but evidence was mixed on effectiveness for remaining population), *available at* http://www.ncbi.nlm.nih.gov/pubmed/20066386.

Consider, then, a program aimed at tobacco cessation that offers a full 50% discount on health coverage costs for completing a stress management workshop and fitness program, but limits the offer to tobacco-using participants ("smokers"). The current language of subsection (f)(3)(iii) and the new reasonable design requirement of subsection (f)(3)(iv) could be read as requiring that similarly-situated non-smokers be given the opportunity to earn the same incentive by satisfying a different standard. Instead, plans should be able to limit this program to smokers because it provides a disproportionate benefit based on an adverse health factor.

Accordingly, ERIC seeks confirmation that the Departments endorse the Department of Labor's prior guidance on benign discrimination in FAB 2008-02. ERIC also seeks confirmation that when an incentive program is offered only to those individuals with "adverse" health factors, neither subsection (f)(3)(iii) nor (f)(3)(iv) requires that participants lacking the targeted adverse health factor be given a reasonable alternative to earn the reward.

E. Retain a workable and effective definition of "reasonable design"

The Departments have requested comments on the revised definition of reasonable design in subsection (f)(3)(iv).[24] For the most part, the proposed regulation's reasonable design standards are consistent with the 2006 regulations. Among many positive hold-over features are the flexibility to innovate with new program designs. One significant change from the 2006 regulations concerns us: the requirement to offer a "different, reasonable means of qualifying for a reward" for programs with incentives contingent on a measurement, test, or screening.

ERIC is unaware of any reason to believe that measurement-based health-contingent programs are less likely to improve health or more likely to harm those with adverse health conditions. Thus, we are apprehensive about the newly added sentence stating that, if a plan's initial standard for obtaining a reward is based on the results of a measurement, test, or screening relating to a health factor, then "the plan must make available to any individual who does not meet the standard based on the measurement, test, or screening a different, reasonable means of qualifying for the reward." Under some interpretations, this approach would override subsection (f)(3)(iii) and require alternative standards for all individuals, even those for whom there is no reason to believe that achieving the health measure would be medically inadvisable or unreasonably difficult.

For example, a plan might offer a 20% premium discount to any participant with a BMI under 30 on the first day of the plan year. Individuals who did not meet this standard on the first day of the plan year might be given the opportunity to retroactively qualify for the 20% discount by recording a BMI under 30 on the first day of the second or third quarters of the plan year. Individuals for whom it is unreasonably difficult or inadvisable due to a medical condition to achieve a BMI under 30 in this timeframe could be given an alternative standard appropriate to that individual pursuant to (f)(3)(iii), such as a 10% reduction in BMI.

What is important to clarify, however, is that under these circumstances, no individual need be provided a reasonable alternative standard unless the original standard (achieving a BMI under 30) is unreasonably difficult for that individual to meet due to a medical condition or for whom it is medically inadvisable to attempt due to a medical condition.

Wellness programs cannot achieve their goals of incentivizing participants to adopt healthier life styles and behaviors if any measured standard will be weakened for all individuals who request an alternative, regardless of medical condition.

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[24] *See* preamble, 77 Fed. Reg. at 70625.

Further, it should also be made clear that a plan that meets the general 2006 criteria for a reasonable design, i.e., that it is reasonably designed to promote health or prevent disease, has a reasonable chance of improving the health of, or preventing disease in, participating individuals, is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease, will satisfy the reasonable design requirements for procuring the wellness reward.

To the extent that this demanding standard is satisfied, there is no need to raise an additional hurdle for wellness programs, especially one whose meaning is susceptible to many different interpretations. Thus, we recommend that the last sentence in subsection (f)(3)(iv) be deleted.

ERIC reserves the right to submit additional comments on this subsection of the proposed regulation.

F. Retain changes to form notice regarding the potential for reasonable alternatives

The Departments have requested comment on the new form language under subsection (f)(3)(v) for notifying participants of the availability of reasonable alternative means of qualifying for rewards.[25] ERIC commends the open tone and clarity in the new form language and examples. ERIC also appreciates the Department's ongoing recognition that "substantially similar language" may be more helpful than form language, depending on the context. Clear communication with participants is critical for the wellness program partnerships between plans and participants to succeed. The proposed changes advance this goal.

II. Coordination of Related Health Care Regulations

The effectiveness of these proposed regulations in spurring wellness program expansion and improvement is hampered by roadblocks that appear elsewhere in the regulatory landscape. An ongoing concern is the counterproductive restrictions that the Genetic Information Nondiscrimination Act ("GINA") and Americans with Disabilities Act ("ADA") place on wellness programs.

We are also concerned that wellness programs will be disadvantaged by failing to properly account for their positive impact in the grandfathered plan and shared responsibility provisions of the ACA.

We will defer our comments on the affordability test under the shared responsibility regulation to our comment letter on that regulation. In the meantime, ERIC suggests that the Departments:

- Facilitate equal access to wellness programs by clarifying that grandfathered plan status is determined without reference to wellness incentives;
- End GINA prohibitions on use of incentives in requests for family history information and use of family medical history in disease management outreach; and
- Reconcile the ADA rules on health incentives with HIPAA rules.

A. Clarify that "grandfathered plan" status is determined without reference to wellness program adjustments

The proposed regulations invite both grandfathered plans and non-grandfathered plans to expand their health-contingent wellness programs to the new 30% and 50% reward limits. Regulatory guidance issued pursuant to ACA section 1251 threatens, however, that an increase in wellness rewards may compromise grandfathered plan status. ERIC urges the Department to exclude the effect of wellness reward modifications when evaluating a plan's grandfathered status.

[25] *See* preamble, 77 Fed. Reg. at 70625.

The ACA exempted grandfathered health plans from certain provisions in order to protect participants from losing their existing plan coverage.[26] Initially, it appeared that due to these exemptions, grandfathered plans would be hamstrung in building upon the success of their health-contingent wellness programs. In authorizing grandfathered plans to share in the ACA's new incentive limits, the Departments gave such plans the flexibility to improve services, a clear benefit to all participants.[27]

A grandfathered plan may lose all ACA exemptions if there is a significant drop in the health care expenses shouldered by the employer or there are sizable increases in participant contributions or cost-sharing requirements.[28] Previous informal guidance from the Departments indicates that grandfathered group health plans may provide wellness rewards, but that penalties (such as cost-sharing surcharges) "may implicate" the cost-sharing standards for retaining grandfathered status "and should be examined carefully."[29] This guidance suggests that the application of a wellness reward to an individual participant might affect the plan's grandfathered status, even if the underlying design of the plan has not changed since March 23, 2010.

Wellness rewards, whether denoted as penalties/surcharges or discounts, are offered to motivate participant health improvement, not reallocate costs between employees and employers. Rewards may be structured as either penalties or discounts for various design reasons, informed by behavioral economics and psychology.[30] For example, a plan may raise its deductible from $50 to $200 and then waive $150 of the deductible for participants who reach a cholesterol count under 200 (or who satisfy a reasonable alternative standard provided in compliance with these regulations). Equivalently, a plan could keep the $50 deductible and impose a surcharge of $150 for neither achieving the cholesterol target nor participating in a reasonable alternative. Neither changes the economic proposition offered to the participant; it simply facilitates cholesterol improvement.

We urge the Departments to make clear that a plan's grandfathered status can be determined without taking into account any reward offered under a workplace wellness program (including any increase in the reward adopted as a result of the increased limit), regardless of whether the wellness reward is structured as a penalty/surcharge or as a discount.

B. Eliminate GINA Obstacles to Information Gathering Efforts that Improve Wellness and Disease Management Programs.

Restrictions on family medical history information under the current GINA Title I regulations unnecessarily frustrate efforts to improve and expand wellness and disease management programs. Family medical history information can be a critical tool for identifying and implementing appropriate preventive measures so that plan participants can avoid health problems that have a genetic component.

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[26] *See* preamble, 75 Fed. Reg., at 34540.

[27] *See* preamble, 75 Fed. Reg., at 70622 ("[T]o avoid inconsistency across group health coverage and to provide grandfathered plans the same flexibility to promote health and prevent disease as non-grandfathered plans.").

[28] Treas. Reg. § 54.9815-1251T; 29 C.F.R. § 2590.715; 45 C.F.R. § 147.140.

[29] DOL, FAQs About the Affordable Care Act Implementation Part II, Question 5 (Oct. 8, 2010), *available at* http://www.dol.gov/ebsa/faqs/faq-aca2.html.

[30] HERO, *supra* note 10, at 894.

Currently, rewarding a participant's completion of an HRA that requests family medical history is regarded as prohibited "underwriting" even if the genetic information is requested after enrollment and has no effect on the individual's coverage.[31] Experience has shown that without the encouragement of a health professional, many participants who would benefit from participation in a disease management program will never enroll.[32] Accordingly, an incentive given for the completion of an HRA is among the most common types of health-contingent programs.[33] GINA should be interpreted to permit an employer group health plan to reward participants for providing family medical history, as long as the plan does not use this information as the basis to deny enrollment, set premiums, or make any other adverse benefit-related decisions.

A group health plan that offers a disease management program often will be most effective if it can utilize family medical history to identify individuals who might benefit from an illness-specific program. If a plan uses family medical history, however, to determine the participant's eligibility for the disease management program, the interim final regulations under Title I of GINA treat the plan as collecting genetic information for prohibited "underwriting purposes." ERIC urges the Departments to make clear that a plan will not be deemed to collect genetic information for "underwriting purposes" when the plan uses the information to identify participants eligible for additional benefits provided on a voluntary basis.

Preventing plans from incentivizing participants for sharing family medical history and from targeting disease management programs based on family medical history does not protect individuals from discrimination; rather, it increases the risk that preventable illnesses will fail to be detected and avoided.

C. Clarify that Wellness Programs Compliant with the Departments' Regulations are Voluntary for ADA Purposes.

The ADA imposes strict limits on the circumstances in which an employer may require medical examinations or gather medical information about current or prospective employees. An exception to this regime allows employers to offer voluntary medical examinations or request voluntary medical histories as long as they keep the information confidential and do not use it for discriminatory purposes.

The EEOC has issued, and repealed, guidance that would confirm that programs designed to meet the HIPAA standards for voluntary wellness programs also will meet the ADA standard. The uncertainty generated by this lack of guidance hinders employers from moving forward to implement, or expand, wellness programs. New guidance is needed to establish that a wellness program operated in compliance with the HIPAA standards (as modified by the ACA) also will satisfy the ADA.

We urge the Departments and the EEOC to work together to permit employers and employees the fullest access possible to the many benefits that accrue from participation in effective workplace wellness programs.

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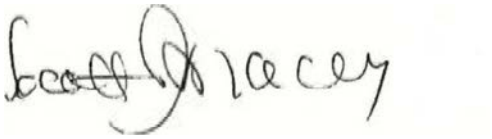
[31] *See* Treas. Reg. § 54.9802-3T(d)(3), Example 1; 29 C.F.R. § 2590.702-1(d)(3), Example 1; 45 C.F.R. § 164.502(a)(5)(i)(A)(1).

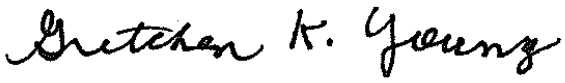
[32] Mattke, *supra* note 10, at 20 (noting that only a third of plans achieved HRA participation rates above 50%).

[33] Kaiser Family Foundation, *supra* note 5, at 180 (noting that 63% of firms with 200 or more employees incentivize HRAs).

ERIC appreciates the opportunity to provide these comments on the notice of proposed rulemaking. If the Departments have any questions concerning our comments, or if we can be of further assistance, please let us know.

Sincerely,





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