DOLLAR GENERAL

Dollar General Corporation
100 Mission Ridge
Goodlettsville, TN 37072
U.S.A.

November 30, 2009

Mr. Dan McGuire
Office Director
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. 20210

Attention: RIN 1210-AB27

Dear Mr. McGuire,

Dollar General Corporation appreciates the opportunity to respond to the Request for Information on Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA). I write to express our serious concerns about the adverse impact of the interim final rules on employer-sponsored wellness and disease management programs and to request that you rescind the regulations.

Dollar General is an industry leader ranked among the Fortune 300, operating in over 9 Distribution Centers and 8,720 stores across the United States, with more than 77,000 employees and annual revenues in excess of $10.5 Billion. In addition, Dollar General is a member of the National Business Group on Health (NBGH), an organization made up of over 280 companies, mostly very large employers, who provide health coverage to more than 55 million U.S. employees, retirees, and their families. The NBGH includes not only large public sector employers, but also 130 of the Fortune 500 companies with 58 members among the Fortune 100. Dollar General, the National Business Group on Health, and NBGH associate companies strongly oppose the interim rules as drafted and ask that you repeal the measure.

As you are aware, group health plans use health risk assessments to identify people with health risks and offer programs and benefits that will reduce those risks. Health risk assessments provide opportunities for referral to preventive care, disease management programs, health promotion and other behavioral change initiatives. All of these programs are critical in keeping participants healthy, helping sick participants get better, and helping chronically ill participants maintain or improve their health condition. Medical histories and genetic information are essential for matching care to the needs of every patient, and incentives designed to motivate people to maintain and improve their health are necessary to control the rising cost of health care.

To that end, questions about family medical history are vital for identifying plan participants who may particularly benefit from wellness initiatives and disease management programs and directing them to the appropriate programs and resources. Without family medical history, clinicians and coaches will lose information about a key risk factor, often the only one present that may identify plan participants at higher risk for cardiovascular disease, some cancers, diabetes or other major chronic conditions – the very ones who could benefit from intervention to prevent debilitating disease, death, and the development of other risk factors.

Numerous studies and our own experiences illustrate that incentives drive significant increases in completion of health risk assessments. As an example, when Dollar General introduced health risk assessments several years ago with only a limited incentive, participation was 9%; when we added a premium credit incentive, participation increased to over 50%. For this reason, it is essential that group health plans be allowed to continue to use incentives to motivate plan participants to complete health risk assessments and actively engage in programs to promote their health and well-being. Limiting the use of incentives to encourage participants to do what is best for their own health erodes the impact of these programs as most individuals need strong encouragement and support to make that initial commitment to a behavior change that promotes good health.

Implementing the rules, as they are now promulgated, will severely limit the ability of group health plans to identify those who can most benefit from these valuable programs that promote wellness, help maintain health and manage chronic disease. The rules will have serious unintended consequences impairing the ability of employer-sponsored group health plans to improve quality, care coordination, medical outcomes and lower costs.

As a practical matter, family or genetic history information on the health risk assessment is not usually available to employers and not an area where abuse occurs. Also, legislation and agency rules guard against misuse of clinical information and there are provisions already in place to ensure that family medical or genetic information is protected, kept confidential, and is only used for purposes of selection of appropriate clinical programs to best meet the health needs of participants. Therefore, removal of family medical or genetic questions from health risk assessments is both unnecessary to protect participants and an unnecessary clinical barrier to providing appropriate healthcare and promoting healthy living.

In summary, we hope you will agree that obtaining family medical history is vital for a successful assessment of an individual's health risk and that providing incentives for completion of assessments is necessary to drive participation in programs designed to improve the health of our population and to control costs. If the rules as set forth are implemented, they will seriously limit our ability to control costs in a way that promotes good health and quality interventions.

Thank you, again, for your consideration of these important issues.

Sincerely,

Bob Ravener
SVP CHIEF PEOPLE OFFICER

cc: The Honorable Phyllis Borzi, Assistant Secretary of Labor for Employee Benefits Security
Mr. Stephen Llewellyn, Executive Director, Executive Secretariat, Equal Employment Opportunity Commission
The Honorable Timothy Geithner, Secretary, U.S. Department of Treasury
The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Office of Health Plan Standards and Compliance Assistance
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