



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4780
Fax 202.626.4833

August 16, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services

The Honorable Hilda Solis
Secretary
U.S. Department of Labor

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury

Attention: OCIO-9991-IFC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via the Federal Regulations Web Portal, <http://www.regulations.gov>

**Re: Comments on the Interim Final Rule Relating to “Grandfather” Status
under the Affordable Care Act**

Dear Secretaries Sebelius, Solis, and Geithner:

The Blue Cross and Blue Shield Association (“BCBSA”) appreciates the opportunity to provide comments to the Departments of Health and Human Services, Labor, and the Treasury (“the Departments”) regarding the Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (“Affordable Care Act” or “ACA”) (the “Rule”). 75 Fed. Reg. 34538 (June 17, 2010). BCBSA represents the 39 independent Blue Cross and Blue Shield Plans (“Plans”) that provide health coverage to nearly 100 million – one in three – Americans.

We are pleased to offer our comments in response to the Departments’ request for comments on the Rule as issued in the *Federal Register* on June 17, 2010.

Our comments include specific recommendations for changes to the Rule, as well as requests for clarification on particular areas of the Rule.

In particular, we recommend the Departments provide greater flexibility to Plans so that certain activities – whether done in the regular course of business or required by federal or state law – do not cause the loss of grandfather status. BCBSA is concerned that some aspects of the Rule are restrictive with respect to changes in benefits and cost-sharing that will cause a group health plan or insurance policy to lose its grandfathered status. The Rule could also subject issuers to penalties for non-compliance with the ACA for actions that an employer or other plan sponsor may take *without* notifying the issuer.

To address this issue, BCBSA recommends that the Departments modify the Rule to provide group health plans and issuers with greater flexibility and certainty as to benefit plan or coverage changes that may trigger a loss of grandfather status. This could be done by either eliminating or modifying the Rule's provision regarding a decrease in employer contributions by more than five percent as triggering a loss of grandfather status given that an issuer may not know whether an employer has decreased its contribution rate below the level in effect on March 23, 2010.

BCBSA also recommends that the Departments modify the Rule to allow the following actions without impacting grandfather status:

- **Changes to benefits or cost-sharing that are adopted pursuant to law**, even if such changes would otherwise implicate the Rule's restrictions on changes to benefits or cost-sharing;
- **Voluntary decisions by an individual policyholder to increase cost-sharing or reduce benefit coverage**;
- **Issuance of a new policy by an issuer (or its affiliate) to the same policyholder for legitimate business reasons**, where the benefits under the new policy are substantially the same as the benefits under the prior policy;
- **Adjustments to enrollee cost-sharing** (including deductibles, copayments, and coinsurance) where the actuarial value of the plan or policy with respect to the plan (or insurer) and participant share of the cost would remain within five percent of the original value as of the date of the ACA's enactment, and permitting changes to cost-sharing for non-essential benefits;
- **Changes from coinsurance to copayments**, given that such a transition would be a benefit improvement for enrollees;

- **Changes to prescription drug benefits and pharmacy networks;**
- **Changes to plan or policy terms**, such as dependent eligibility and medical treatment settings, where meaningful coverage for the benefit or condition is maintained; and
- **Changes to wellness programs' provider or incentives.**

We also recommend that the Departments clarify that the “notice of grandfather status” required by the Rule may be provided annually as part of the group health plan or issuer’s summary plan description or enrollment materials, rather than in “any” communication regarding plan or policy benefits.

BCBSA’s specific comments on these issues are set forth below.

I. Decrease in Employer Contributions

Issue

The Rule provides that a group health plan or health insurance coverage ceases to be a grandfathered plan if an employer (or employee organization) decreases its contribution rate “towards the cost of any tier of coverage for any class of similarly situated individuals...by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.” 45 C.F.R. § 147.140(g)(1)(v). The Rule does not address, however, whether – or the manner in which – this provision may apply with respect to an issuer of a grandfathered group health policy where the issuer has no knowledge as to whether a plan sponsor has decreased its contribution rate toward coverage.

Issuers of group health plan coverage usually do not know when an employer changes its contribution rate. Rather, employers allocate the cost of coverage between themselves and their employees, and remit one monthly premium to the issuer without advising the issuer as to the allocation formula. And employers do not notify issuers of changes to the allocation formula.

In the absence of clarification by the Departments, an issuer could be deemed non-compliant with ACA – and therefore subject to penalties under section 2723 (as renumbered by the ACA) of the Public Health Service Act (“PHSA”) – for continuing to provide a grandfathered policy to an employer that has decreased its contribution rate by more than five percent, even if the issuer was not notified of such decrease.

Recommendation

BCBSA recommends that the Rule provide that an issuer will not be deemed non-compliant with the ACA if it continues to offer a grandfathered policy to an employer or employee organization that has decreased its contribution rate toward any tier of coverage by more than five percent, where the issuer requires (through contract or otherwise) that the employer disclose the employer contribution rate and provide advance notice to the issuer of any change to such contribution rate, but the employer fails to do so.

II. Changes Required By Law

Issue

The preamble to the grandfather Rule provides that “group health plans and health insurance issuers will not cease to be considered grandfathered if the plan sponsor or issuer makes changes to comply with Federal or State legal requirements[.]” 75 Fed. Reg. at 34544. However, the Rule is not specific regarding how changes to comply with law that involve reduced benefits or increased cost-sharing (including coinsurance) will be treated under the Rule, where the group health plan or issuer could otherwise comply with law by not making a change that implicates the Rule, or whether such changes would be covered under the good faith compliance period.

An example of the confusion caused by the Rule is the way in which many group health plans and issuers adopted benefit changes between March 23 and June 14, 2010, for purposes of complying with the Mental Health Parity and Addiction Equity Act (“MHPAEA”) and its accompanying regulations (which were applicable as of July 1, 2010). These changes included modification of cost-sharing requirements for mental health/substance abuse and medical/surgical benefits, which were adopted to satisfy the MHPAEA regulation’s “predominant/substantially all” test, but which could otherwise exceed the parameters established by the Rule, which was not publically available until June 14, 2010. Further, it is entirely possible that Congress or a state could enact legislation in the future that – similar to MHPAEA – provides plan sponsors and issuers with options as to how to comply with the law.

Recommendations

The final rules should provide that any change in a group health plan or policy designed to comply with federal or state laws should not result in loss of grandfather status. The concept that group health plans or policies lose grandfather status due to changes in terms is based on the idea that if an employer or individual want different health benefits, the amended health benefits should be subject to the provisions of the ACA. However, where group health

plan or policy changes are required by law, employers or individuals did not make choices that should subject them to ACA requirements, so compliance with new laws should not cause loss of grandfather status.

BCBSA also recommends that the grace period be extended from an end date of June 14 (the date of publication of the Rule) to September 23, 2010, during which members may return to a grandfathered plan if they unknowingly changed to a non-grandfathered plan. This approach is necessary because the rules were issued mid-June with comments due mid-August, but the implications of grandfathering are only now coming into focus.

This language should be included in the actual text of the rules, not only in the preamble. Some courts hold that language included in the preamble is not entitled to deference by the courts¹, so including these provisions in the actual rule text will assure the Departments' views are accorded proper deference by the courts.

III. Disclosure of Grandfather Status

Issue

As currently drafted, the Rule provides that a group health plan or issuer "must include a statement, in *any* plan materials provided to a participant or beneficiary...describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan[.]" 45 C.F.R. § 147.140(a)(2) (emphasis added). A literal reading of this provision would require group health plans and issuers to include the notice in each and every communication that it sends to participants, including explanation of benefit statements ("EOBs"), subrogation notices, and routine communications to participants.

Recommendation

The Rule should clarify that a group health plan or issuer's disclosure obligation is satisfied by inclusion of the grandfather plan notice in the summary plan description ("SPD") and/or annual enrollment or renewal materials. Given that the preamble to the Rule expresses the Departments' view that the notice requirement would impose only a "*one-time* cost to group health plans and insurance issuers of preparing and distributing the grandfathered health plan disclosure," and a "*one-time hour burden*" with preparing and reviewing the notice for inclusion in the "plan document," 75 Fed. Reg. at 34554-56, this

¹ See *Langbecker v. Elec. Data Sys. Corp.*, 476 F.3d 299, 311 n. 22 (5th Cir. 2007) (no deference to footnote in preamble to regulations because it "...constitutes at best a comment on the regulations, and is not itself a regulation").

clarification is appropriate to avoid a requirement that group health plans and issuers include the notice on any document they issue.

The Departments should also clarify that the grandfather notice is not required to be included in the group health plan document or insurance policy itself, given that such a requirement could force issuers to re-file all of their policy and certificate forms with state insurance departments to incorporate the form notice, which is overly burdensome for both issuers and state regulators. Accordingly, the Rule should require only a stand-alone notice of grandfather status, which could be included in an SPD or enrollment or renewal materials.

IV. Voluntary Decisions by Individual Policyholders to “Buy-Down” Coverage Should Not Trigger a Loss of Grandfather Status

Issue

It is common for policyholders in the individual market to voluntarily request that the issuer increase the policyholder’s deductible or other forms of cost-sharing (such as coinsurance, copayments and out-of-pocket maximums), or to decrease benefits by eliminating coverage for certain conditions. Policyholders initiate these requests for reduced coverage (which are commonly known as “buy-downs”) to reduce their premiums, and they usually do so as a result of a significant change in the policyholder’s financial situation, such as the loss of a job.

The Rule provides that a group health plan or policy will lose grandfathered status if, among other things, there is:

- a. The elimination of all (or substantially all) benefits to diagnose or treat a particular condition;
- b. Any increase in coinsurance above the level in effect on March 23, 2010;
- c. An increase in deductible, out-of-pocket maximum, or other fixed-amount cost-sharing that is more than medical inflation plus 15 percent (measured from March 23, 2010); or
- d. An increase in copayment in an amount greater than \$5 increased by medical inflation, or medical inflation plus 15 percent (measured from March 23, 2010).

45 C.F.R. § 147.140(g)(1)(i)-(iv). The Rule, however, does not address whether a benefit modification that is *voluntarily* initiated by a policyholder in the individual market, which would otherwise exceed the parameters established by the Rule, triggers a loss of grandfather status. A common example is when an individual

market policyholder drops a coverage that is no longer needed or appropriate, for example, maternity coverage for a woman who no longer wishes to have this coverage.

Recommendation

BCBSA recommends that the Departments modify the Rule to specify that grandfathered individual insurance coverage will not lose such status where the policyholder voluntarily initiates an increase in his or her cost-sharing (such as increasing the deductible, copayments, coinsurance or out-of-pocket maximum), or otherwise decreases benefits by eliminating coverage for certain conditions that are optional to such coverage.

There are substantial policy reasons for issuing this clarification. Among other things, the change in coverage is voluntarily initiated by the individual policyholder who is covered by the insurance (*i.e.*, it is not initiated by an insurer or an employer). Often, these changes are initiated for purposes of maintaining coverage at a lesser premium following the loss of a job or some other similar event. If a voluntary reduction in coverage triggers the loss of grandfather status, it would force the policyholder to either: (a) buy a new policy that is subject to the full array of the ACA's insurance market reforms – which is likely to be higher in premiums than the grandfathered policy – at a time when the individual is facing considerable financial uncertainty and is trying to *reduce* his or her premiums; or (b) drop coverage altogether, which is contrary to the ACA's goal of expanding coverage. If they drop coverage, these policyholders will not be eligible for the Pre-Existing Condition Insurance Plan established by the ACA for at least six months following their loss of coverage, given that individual coverage is "creditable coverage." See ACA § 1101(d)(2). Moreover, these policyholders will not be eligible for federal subsidies available through the Exchanges until 2014.

V. Issuance of Substantially Identical Coverage from an Issuer or its Affiliate

Issue

Issuers commonly issue new policies or certificates to the same policyholders (*i.e.*, that are substantially the same as a previously issued policy or certificate) for legitimate business reasons. For example, an issuer may transfer a book of business to a newly established subsidiary. Or, an issuer may seek to consolidate duplicate policy forms into a smaller number of nearly identical policy forms for administrative purposes. In these circumstances, a new policy or certificate may be issued to the policyholder that details the name as the issuer (or its affiliate), a new policy or certificate number, and certain other "ministerial" matters (such as the address to which notices should be sent, etc.), but the

benefits under the new policy or certificate are virtually identical to the benefits offered under the transitioned policy.

The Rule defines a “grandfathered health plan” as “coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for so long as it maintains that status under the rules [of the Rule].” 45 C.F.R. § 147.140(a). And the Rule further provides that “if an employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010 (because, for example, any previous policy, certificate, or contract of insurance is not being renewed), then that policy, certificate, or contract of insurance is not a grandfathered health plan with respect to the individuals in that group health plan.” 45 C.F.R. § 147.140(a)(ii). The Rule does not address, however, whether grandfathered status may be maintained where a new policy or certificate of insurance is issued for legitimate business reasons and where the coverage is issued by the same insurer (or an affiliate), to the same policyholder, and where the coverage is substantially the same.

Recommendation

BCBSA recommends that the Departments modify the Rule to clarify that where a new policy or certificate is issued by an issuer (or its affiliate) for legitimate business reasons, and pursuant to which the issuer (or affiliate) continues to cover the same policyholder and to offer the same benefits (or benefits that are within the parameters established by the Rule), the policy or certificate is treated as effectively continuing the same coverage that was in force on March 23, 2010, and retains its status as a grandfathered health plan. In these circumstances, the same policyholder is covered by an entity that is the same issuer (or affiliate) and the benefits available under the policy or certificate are identical or substantially identical (as permitted by the Rule) to the coverage that was in effect on March 23, 2010. We note that, in other circumstances, regulators have recognized that similar changes should not disqualify an insurance policy from eligibility for grandfather status. See, e.g., Dep’t of Labor (“DOL”) Adv. Op. 2000-12A (October 4, 2000) (amendments to group annuity contracts to accommodate changes in a plan sponsor’s corporate structure are not material, and will not disqualify such policies from their status as “transition policies” under DOL regulation issued pursuant to ERISA § 401(c)(1)).

VI. The Rule Should Permit Greater Flexibility With Respect to Cost-Sharing

Issue

The Rule limits a plan sponsor or issuer’s ability to modify cost-sharing provisions in the group health plan or coverage without triggering a loss of grandfather

status. Specifically, the Rule provides, in pertinent part, that a group health plan or policy will lose its grandfathered status if the sponsor or issuer makes any of the following changes to cost-sharing:

- a. Increases coinsurance (or another percentage cost-sharing requirement) above the level at which it set on March 23, 2010;
- b. Increases fixed-amount cost-sharing requirements *other* than copayments, such as a deductible or an out-of-pocket limit, by a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation plus 15 percent; or
- c. Increases copayments above the level in effect on March 23, 2010, by an amount that exceeds the greatest of (i) the sum of medical inflation plus 15 percent, or (ii) \$5 increased by medical inflation.

45 C.F.R. § 147.140(g)(1)(ii)-(iv). In the Preamble to the Rule, the Departments note that:

[M]any plan sponsors and issuers make changes to the terms of plans or health insurance coverage on an annual basis: Premiums fluctuate, provider networks and drug formularies change, employer and employee contributions and cost-sharing change, and covered items and services may vary. Without some ability to make some adjustments while retaining grandfather status, the ability of individuals to maintain their current coverage would be frustrated, because most plans or health insurance coverage would quickly cease to be regarded as the same group health plan or health insurance coverage in existence on March 23, 2010.

75 Fed. Reg. at 34546. Notwithstanding this recognition, however, the Rule adopts unnecessarily restrictive limits to cost-sharing that severely limit a plan sponsor's ability to control costs, and which do not accurately reflect the factors that plan sponsors and issuers take into account when considering benefit design issues.

Among other things, the Rule's limits on changes to cost-sharing are all based upon the rate of medical inflation. The rate of medical inflation, however, does not take into account the full scope medical cost trend, or benefit, utilization, new technologies and demographic changes that may significantly increase a group health plan's costs above the rate of medical inflation – especially when measured from March 23, 2010, as the Rule requires, rather than annually.²

² The Rule requires that changes to cost-sharing be measured from March 23, 2010, rather than annually, given that “the effect of a one-time allowance (15 percent of the original, date-of-enactment level plus medical inflation) would diminish over time insofar as it would represent a

Recommendations

BCBSA recommends that the Departments modify the Rule to eliminate the prohibition on any changes to coinsurance, and the prohibition on changes to deductibles, out-of-pocket maximums, or copayments that exceed the parameters set forth in the Rule. Instead, the Departments should permit changes to a policy or group health plan's cost-sharing provisions (*i.e.*, copayments, deductibles, co-insurance) without the loss of grandfather status by a greater amount that would ensure that normal changes made by group health plans and issuers to mitigate premium increases, perhaps by using historical averages for benefit trends rather than CPI+15. In addition to changes in cost-sharing, we request that the guidance permit some changes to a policy's benefits that would not substantially alter the benefits provided under the coverage on a year-over-year basis.

The Departments rejected an actuarial equivalence standard for purposes of the Rule, on the grounds that such a standard could permit a group health plan or issuer "[to] make fundamental changes to the benefit design," and because "the complexity involved in defining and determining actuarial value" would require the Departments to promulgate very detailed prescriptive rules." 75 Fed. Reg. at 34547.

In developing a final regulation, the Departments should consider a standard that better reflects historical benefit cost trends, and the factors that should comprise such a standard. There is a significant need to correct for the difference between CPI and the benefit cost inflation if grandfathering is to have value. BCBSA would be pleased to work with the Departments in developing such a standard.

We also recommend that the Departments modify the Rule to expressly permit group health plans and issuers to move from coinsurance to copayments for specific benefits or services without loss of grandfather status, given that participants generally view such a modification as a significant benefit improvement.

Additionally, the Departments should amend the Rule to provide that changes to cost-sharing with respect to non-essential benefits will not trigger a loss of grandfather status. In enacting the ACA, Congress was clearly focused on ensuring that participants had access to coverage for essential benefits, as defined by ACA § 1302. Given that non-essential benefits were not a subject of Congressional concern due to the incidental nature of such benefits, there is no reason for the Departments to treat cost-sharing changes as to non-essential benefits as implicating the group health plan's or coverage's grandfather status.

diminishing fraction of the total level of cost-sharing with the cumulative effects of medical inflation over time." 75 Fed. Reg. at 34546.

VII. Changes to Prescription Drug Formularies and Benefits Should Not Cause a Loss of Grandfather Status

Issue

In the Rule, the Departments invite comments as to whether changes to a group health plan's or coverage's prescription drug formulary should trigger a loss of grandfather status, and, if so, "what magnitude of changes would have to be made" to trigger such a loss. 75 Fed. Reg. at 34544.

Recommendations

BCBSA respectfully submits that changes to a prescription drug formulary should *not* trigger a loss of grandfather status.

Restricting a plan sponsor's or issuer's ability to make changes to its prescription drug formulary – or to its prescription drug benefit program in general – would severely restrict the sponsor or issuer's ability to control a key component of rising health care costs with no appreciable benefit to group health plan participants or to insured individuals. Pharmacy benefits are particularly dynamic and *must* be modified to reflect constant changes in the industry, including changes to formularies for safety purposes as well as to accommodate changes in brand to generic drug status, and the needs of group health plan participants or of insured individuals. For example, new drugs are continuously introduced to the market, other drugs may be removed from the market, and lower-cost generic equivalents regularly become available. There is no reason why formulary changes to reflect the addition of new drugs, the removal of certain drugs, or the availability of generic or therapeutic equivalents should trigger a loss of grandfather status.

We also recommend that changes to a group health plan's or coverage's pharmacy network should not trigger a loss of grandfather status. Group health plans or issuers may be required to change pharmacy networks if a large pharmacy provider discontinues its participation in the network, which requires the group health plan or issuer to look for an alternate network that can provide geographically convenient access to group health plan participants or insured individuals. Or, a group health plan or issuer may change networks as a result of securing more favorable reimbursement rates with a new network. In negotiating changes in a pharmacy network, group health plans and issuers have an inherent incentive to ensure that participants have convenient geographic access to contracted pharmacies, given that a failure to provide such access would defeat the group health plan's or issuer's attempt to steer a greater percentage of participants to contracted providers.

Further, many group health plans and issuers also use independent pharmacies that may relocate or close, triggering a network change under the Rule. These kinds of routine adjustments should not cause loss of grandfather status.

Accordingly, the Departments should recognize in the Rule that any change to a pharmacy network will not cause a loss of grandfather status.

VIII. Changes to Provider Networks Should Not Trigger Loss of Grandfather Status

Issue

The Departments also requested comments as to whether changes to a group health plan's or issuer's provider network should trigger a loss of grandfather status, and, if so, "what magnitude of changes would have to be made" to trigger such a loss. 75 Fed. Reg. at 34544.

Recommendations

BCBSA respectfully submits that changes to a provider network should *not* cause the loss of grandfather status.

Plan sponsors and issuers work diligently to maintain stable provider networks that provide participants with convenient access to physicians and hospitals and other providers. Nevertheless, some change in the composition of a network is inevitable, given that institutional providers merge, modify the services they provide, or exit particular markets. Likewise, physicians and other professionals may close their practices, retire, relocate, or die. These routine changes in provider networks are commonplace, and do not have a significant impact on a participant's access to health care providers or services. Accordingly, routine changes to provider networks, such as provider turnover, should not cause a group health plan or coverage to lose grandfather status.

A group health plan or coverage should not lose grandfather status based on a change in network providers. As noted above in connection with pharmacy benefits, group health plans and issuers may modify provider networks for a number of reasons: a geographically significant provider may discontinue its participation in the network, forcing the group health plan or issuer to seek an alternate provider that can provide services to participants; or a group health plan or issuer may negotiate more favorable reimbursement rates with a new provider network that will result in cost-savings for the group health plan or issuer (and participants, in the form of lower premiums and cost-sharing). But as is the case with pharmacy networks, group health plans and issuers have an inherent incentive and obligation to assure that participants have convenient access to network providers, given that a failure to provide such access would defeat the

group health plan's or issuer's attempt to steer a greater percentage of participants to network providers.

Accordingly, BCBSA submits that any changes to a provider network should not trigger a loss of grandfather status, where the network change does not alter the policy or group health plan's benefit design.

IX. Changes to Plan or Policy Terms that Do Not Eliminate Benefits Should Not Trigger a Loss of Grandfather Status

Issue

The Departments invited comments on changes to group health plan or insurance coverage that would cause a loss of grandfather status. 75 Fed. Reg. at 34544.

Recommendations

BCBSA recommends that the Departments modify the Rule to clarify that changes to a group health plan's or coverage's eligibility criteria or plan or policy terms that do not eliminate all or substantially all benefits to treat a particular condition will not cause the group health plan or coverage to lose grandfather status. For example, it is common for group health plans and issuers to alter their dependent eligibility criteria under group or individual health plans, including the addition of a "tier" structure (*i.e.*, moving from "employee" to "employee +1" "employee + 2", etc.).

X. Changes to Plan or Policy Wellness Programs Should Not Cause the Loss of Grandfather Status

Issue

The Rule does not address whether changes to a wellness program will trigger the loss of grandfather status. Given that the incentives and benefits offered by wellness programs may frequently change to address medical conditions and lifestyles of group health plan participants or insured individuals, an expansive interpretation of the Rule could lead to the conclusion that a change to a wellness program's incentives or benefits may trigger the loss of grandfather status for the entire group health plan or coverage. Such an interpretation of the Rule would be contrary to clear Congressional intent. Wellness programs are dynamic programs that are subject to revisions, as plan sponsors and issuers modify such programs to increase participation, and incentivize behavioral changes (such as increasing the number of non-smokers). Wellness programs are often offered by

specific companies and frequently are offered outside of a group health plan or group health insurance coverage.

Under HIPAA, wellness programs are permitted to provide rewards based on health status, provided that the reward is limited to 20 percent of the cost of coverage. For example, a wellness program may provide an additional vacation day or deductible credit of a limited amount for employees who do not smoke or who have favorable cholesterol levels. These programs must comply with a number of other requirements, including providing the same reward to those who cannot meet the standard for medical reasons. The HIPAA regulations expressly use premium and deductible differences as examples of permitted rewards. These rewards tend to be temporary in nature (*e.g.*, they are provided for as long as the employee remains smoke-free, or may be modified to further incentivize changes in behavior). Given the ever changing nature of wellness program providers and incentives, changes to such programs do not appear to fit within the more permanent, substantive changes contemplated by the Rule.

The Rule provides that “[t]he elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan. For this purpose, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.” 45 C.F.R. § 147.140(g)(1)(i). The Rule also provides that a change in deductible or out-of-pocket maximum that is greater than medical inflation plus 15 percent (measured from March 23, 2010), or a change in copayment that is greater than (a) medical inflation plus 15 percent or (b) \$5 plus medical inflation (measured from March 23, 2010) will cause the group health plan or coverage to lose grandfather status.

Recommendations

BCBSA recommends that the Rule recognize the unique features of wellness programs and clarify that changes to wellness program providers or incentives will not trigger a loss of grandfather status. In enacting the ACA, Congress encouraged plan sponsors and issuers to offer wellness programs. For example, the ACA raises the cap on the allowed value of a wellness program reward from 20 percent to 30 percent of the cost of employee coverage, and it gives discretion to the Departments to increase the reward value up to 50 percent. PHSA § 2705(j)(3)(A). The ACA also established reporting requirements for certain group health plans and insurers that implement wellness and health promotion activities (PHSA § 2717), and it established a grant program to assist employers in establishing and evaluating workplace wellness programs. ACA § 10408.

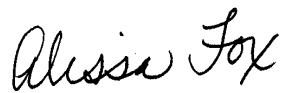
BCBSA also recommends that changes to utilization review programs (*e.g.*, preauthorization) – when there is no change in benefits – should not cause a loss of grandfather status. These programs are dynamic and are designed to

manage utilization of health care services. This should include changes to both in and out of network benefits if there is no change to contracts.

* * *

We appreciate your consideration of our comments and recommendations on the Rule. We look forward to continuing to work with the Departments on implementation issues related to the ACA. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,

A handwritten signature in cursive script that reads "Alissa Fox".

Alissa Fox
Senior Vice President
Blue Cross Blue Shield Association