BlueCross BlueShield Association

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By Electronic Mail (e-ORI@dol.gov)

Mr. Robert Doyle
Director
Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
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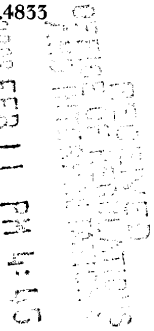

Attention: 408(b)(2) Amendment

Dear Mr. Doyle:

The Blue Cross and Blue Shield Association ("BCBSA") is pleased to provide comment on the Department of Labor's ("the Department") proposed changes to the regulations governing the statutory exemption for the provision of services under section 408(b)(2) of the Employee Retirement Income Security Act of 1974 ("ERISA") (the "Proposed Regulation" or the "Proposed Rule"). 72 Fed. Reg. 70988 (Dec. 13, 2008). BCBSA represents the 39 independent, locally operated BlueCross and BlueShield Plans ("Plans") that collectively provide health care coverage for almost 100 million people, nearly one in three Americans.

As a threshold point, the Proposed Regulation applies to service providers to both pension and health and welfare plans. BCBSA believes that the application of the rule to health and welfare plan service providers is misplaced. Although there has been a great deal of scrutiny by Congress and the Government Accountability Office ("GAO") on the adequacy of disclosure of service provider information with respect to pension plans,[1] there has been less scrutiny as to whether the amount of information provided to health and welfare benefit plan fiduciaries is inadequate. For this reason, BCBSA recommends that all health and welfare plans be excluded from the final rule and that the Department further study whether the regulation should be applied to health and welfare plans based on its experience in implementing the rule with respect

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[1] See *Conflicts of Interest Involving High Risk or Terminated Plans Pose Enforcement Challenges*, GAO Report to Congressional Requesters (June 2007) (focusing on lack of disclosure by service providers to defined benefit plans); *Changes Needed to Provide 401(k) Plan Participants and the Department of Labor Better Information on Fees*, GAO Report to the Ranking Minority Member, Committee on Education and the Workforce, House of Representatives (Nov. 2006) (recommending increased service provider disclosure to fiduciaries and increased fee disclosure to plan participants).

to pension plans. At a minimum, health and welfare plans should be afforded more time to come into compliance with the requirements of the Proposed Regulation.

If the Department applies the final regulation to health and welfare plan service providers, it is critical that rule be revised so that health and welfare plan fiduciaries are provided clear and meaningful information. As drafted, the Proposed Regulation would impose overly broad fee and conflict of interest disclosure obligations on nearly all ERISA plan service providers and commensurately significant burdens on plan fiduciaries to obtain and evaluate the mandated information. If these obligations are not clarified, service providers will never be fully certain that their disclosures are adequate and complete and thus will be needlessly exposed to the threat of civil sanctions under ERISA. Therefore, BCBSA requests that the Department make significant clarifications and revisions so that any new rules are clear and administrable for plan service providers as well as useful for plan fiduciaries.

BCBSA's specific comments on the Proposed Regulation are set forth below.

A. Service Provider Disclosure Standards

BCBSA Recommendation: The Department should provide that a service provider will not lose the protection of the rule if the service provider used "reasonable care" to satisfy all of the disclosure requirements and if the service provider takes prompt action to remedy inadvertent noncompliance.

The Proposed Regulation places significant new burdens on service providers to disclose direct and indirect compensation and potential conflicts of interest. Plan service providers that exercise "reasonable care" in complying with the Proposed Regulation should be deemed in compliance with the regulation so long as the service provider corrects any material omissions or mistakes within a 60 day period after non-compliance is discovered by the service provider or brought to the service provider's attention by the plan fiduciary.

For the first time, service providers will have an affirmative duty to comprehensively disclose all direct and indirect compensation received in connection with the provision of services. In addition, a myriad of "potential conflicts of interest" must also be disclosed. All of these disclosures must be continuously updated. Given the complexities and new burdens involved, even a diligent service provider will make inadvertent mistakes. Failure to provide the required disclosures could result in civil penalties against welfare plan service providers under section 502(i) of ERISA (and excise taxes under section 4975 of the Code for pension plan service providers).

Under the Proposed Regulation, it appears that service providers will be deemed to be in compliance with the regulation if they disclose "to the best of the service provider's knowledge" the compensation or fee information and the conflict of interest information. See Prop. Reg. § 2550.408b-2(c)(1)(iii). As such, we assume, and we ask the Department to confirm in the final regulation, that a service provider will not lose the protection of the rule if the service provider inadvertently fails to satisfy all of the disclosure requirements, provided a certain level of diligence is exercised by the service provider.

However, BCBSA believes that the Proposed Regulation's "best knowledge" standard, which equates to a "best efforts" standard, is an unjustifiably high standard of diligence to impose on service providers entering into arm's-length commercial contracts. The courts have recognized that when service providers engage in contracting, and when they enforce the contracts they bargain for with ERISA plans, they do not have a fiduciary duty to the counterparty.[2] Yet the "best efforts" compliance requirement is an extraordinary obligation, tantamount to a fiduciary standard of care, to make the disclosures required by the Proposed Regulation.

Typical contract standards require contracting parties to exercise "reasonable care" or "good faith" in their undertakings and representations. BCBSA strongly believes that a "reasonable care" standard will impose a meaningful standard on plan service providers without holding them needlessly liable for inadvertent failures. "Reasonable care" is defined as the degree of care that a prudent and competent person engaged in the same line of business or endeavor would exercise under similar circumstances. Black's Law Dictionary (8th ed., 2004). In order to protect plan fiduciaries in the event of inadvertent mistakes, we suggest that the Department couple the "reasonable care" standard with an obligation on the service provider to supply complete disclosures within 60 days of discovering a material omission or mistake.

Importantly, the Department recognized that a "reasonableness" standard or a "good faith" standard was sufficient to protect plan fiduciaries in an analogous regulatory circumstance. In particular, in regulations issued under section 401(c) of ERISA, insurance companies are required to make certain upfront and ongoing disclosures relating to "transition policies" in order for the assets of the insurer that backs the insurance contract to be exempt from "plan assets" treatment. 29 C.F.R. § 2550.401c-1. Under the Department's regulations, the insurer will not be in violation of the disclosure requirements where it makes "reasonable" and "good faith" attempts at compliance and establishes a reasonable process to remedy noncompliance in a timely fashion. Id. § 2550.401c-1(i)(5).

B. Timeframe for Implementation

BCBSA Recommendation: The Department should allow plans and service providers sufficient time to conform current disclosure practices and written contracts to the final regulation.

The Department indicated that it hopes to implement the revisions to the current section 408(b)(2) regulations by January 1, 2009 to coincide with the implementation of the recently finalized Form 5500 revisions. Health and welfare plans have extremely complex contract and subcontracting arrangements as well as open enrollment period requirements that would make

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[2] See Miniat, Inc. v. Globe Life Ins. Group, Inc., 805 F.2d 732 (7th Cir. 1987); Harris Trust & Savings Bank v. John Hancock Mutual Life Ins. Co., 302 F.3d 18 (2d Cir. 2002); Seaway Food Town, Inc. v. Medical Mutual of Ohio, 347 F.3d 610 (6th Cir. 2003) (adherence to a specific term in a contract does not constitute a fiduciary act).

this anticipated effective date very difficult if not impossible to meet. Moreover, health and welfare plan fiduciaries typically enter into many more contracts than fiduciaries of pension plans.

The Department should move back the effective date so that it applies as of January 1, 2010. However, if the Department will not consider delaying the implementation deadline completely, the Department should consider bifurcating the implementation timeframe to apply to pension plans beginning in January 1, 2009 and to allow service providers to health and welfare plans an added one year period to implement disclosure reporting structures. Bifurcation of the implementation deadline would be appropriate because health and welfare plan service providers are typically insurers that offer products in both the insured market (exempt from this rule) and the self-insured market (subject to this rule), are highly regulated under state law for their insured business, are subject to ERISA, and offer a wide variety of complex services arrangements to health and welfare plans.

C. Application to Existing Contracts

BCBSA Recommendation: The Department should clarify that the Proposed Regulation does not require amendment of service provider contracts in effect on the effective date of the Proposed Regulation.

The Proposed Regulation does not clearly explain whether existing contracts must be amended to comply with the disclosure requirements immediately after the effective date of the Proposed Regulation. The final regulation should make clear that amendments to existing service provider contracts need occur only upon contract amendment or renewal. Because of the number and complexity of service provider contracts with health and welfare plans, it would be impossible to amend all such contracts immediately after the effective date of the Proposed Regulation.

If a sooner time period is required, the Department should make clear that the service provider can meet this requirement by providing the required disclosure without formally amending contracts. Because service providers to health and welfare plans may have hundreds, if not thousands, of existing contracts, many with different services and fees, it would be impractical for service providers to health and welfare plans to formally amend all contracts, particularly in a short time period.

D. Insurance Policies

BCBSA Recommendation: The Department should confirm BCBSA's view that the Proposed Regulation does not apply to traditional health and welfare insurance policies.

There has been some confusion as to whether traditional health and welfare insurance policies are subject to the Proposed Regulation because one category of service providers covered under the Proposed Regulation includes persons that provide "insurance" services. This misunderstanding exists even though the Department explicitly stated in the Preamble to the Proposed Regulation that, "The Department believes that an investment of plan assets or the purchase of insurance is not, in and of itself, compensation to a service provider for purposes of

this regulation." 72 Fed. Reg. at 70990. This statement is, of course, consistent with the Department's long held position that the issuance of an insurance contract alone will not cause an insurer to become a service provider party in interest under section 3(14) of ERISA. See DOL Adv. Op. 76-36 (Jan. 15, 1976).

Excluding issuers of traditional insurance policies from the scope of the disclosure obligations under the Proposed Regulation is consistent with the treatment of such contracts under the recently finalized Form 5500 reporting amendments. In this regard, the revised Form 5500 reporting rules require plan administrators to report certain information regarding both direct and indirect compensation received by service providers in connection with providing plan services. Newly revised Schedule C instructions provide that premium payments for insurance contracts that do not involve the separate provision of services should not qualify as "direct" compensation to a service provider for purposes of Schedule C. See 72 Fed. Reg. at 64825 ("The investment of plan assets and the payment of premiums for insurance contracts, however, are not in and of themselves payments for services rendered to the plan for purposes of Schedule C reporting and the investment and payment of premiums themselves are not reportable compensation for purposes of Schedule C."). In addition, both the Department's preamble and revised Schedule C instructions make clear that these insurance policies should not involve the payment of reportable "indirect" compensation for purposes of Schedule C. 72 Fed. Reg. at 64739, 64825 ("Where fully insured group health benefits, or similarly fully insured benefits under a plan, are purchased from and guaranteed by a licensed insurance company, insurance services, or similar organization, and where information regarding that contract is reported on the Schedule A, compensation paid by the insurance company from its general assets to affiliates or third parties for administrative activities necessary for the insurer to satisfy its contractual obligation to provide benefits is not required to be treated as reportable service provider compensation for purposes of Schedule C. This would include compensation for services such as recordkeeping and claims processing services provided by a third party pursuant to a contract with the insurer to provide those services.... Insurance investment contracts are not eligible for this exception.")

While BCBSA believes it is clear that health and welfare insurance policies would not be subject to the requirements of the Proposed Regulation, we nonetheless ask the Department to clarify the final rule to clearly state that these insurance policies are not subject to the revised 408(b)(2) requirements.

E. Definition of Fiduciary

BCBSA Recommendation: The definition of service provider in the final rule should follow ERISA's definition and should not include a fiduciary under the Investment Advisers Act of 1940.

The first category of service providers that would be subject to the new disclosure requirements are those entities that provide services as a fiduciary as defined in ERISA or the Investment Advisers Act. Using a securities law definition of fiduciary in the Proposed Rule that does not track the ERISA definition of fiduciary is inappropriate and adds a new level of uncertainty as to the scope of the rule since the Investment Advisers Act definition is sometimes narrower, and sometimes broader, than the ERISA definition. Most importantly, there is no need for the

Department to create the uncertainty of referencing a fiduciary under the Investment Advisers Act since the current categories of service provider under the regulation are sufficiently broad to capture those persons who may not be ERISA fiduciaries but may be Investment Advisers Act fiduciaries (e.g., consultants).

F. Bundled Services Rule

BCBSA Recommendation: The definition of "bundled" services arrangements under the Proposed Regulation is ambiguous and should be clarified with respect to common welfare plan arrangements.

"Bundle of services" is defined in the Proposed Regulation as "a bundle of services . . . priced as a package, rather than on a service-by-service basis." Prop. Reg. § 2550.408b-2(c)(1)(iii)(A)(3). The Preamble to the Proposed Regulation clarifies that "the responsible plan fiduciary obtains a 'package deal' and will negotiate only with the provider of the bundle." 72 Fed. Reg. at 70991. This is a very broad definition and will be difficult for welfare benefit service providers to interpret given their multiple service arrangements and complicated service provider relationships.

It is important for the Department to clarify the intended application of the definition of "bundled services" by providing examples of what would constitute a bundled arrangement with respect to welfare plan service providers. Such clarity will help ensure consistent and appropriate disclosures by health plan service providers. BCBSA specifically requests the Department confirm that bundled providers include the following scenarios:

- A plan enters into a single contract with a Third Party Administrator (TPA) under which the plan may obtain claims processing, enrollment services, access to medical, dental or vision programs and provider networks, disease management and health information technology; and/or

- A plan enters into a single contract with a PBM under which the plan may obtain claims processing, access to a formulary of prescription drugs, access to prescription drug rebates on brand drugs, and access to a network of pharmacies (including retail, specialty or mail order).

In addition, we note that, under the bundled services rule, payments by the service provider to affiliates, subcontractors or other parties would not have to be disclosed unless there is a charge directly against a plan investment or if the payment is set "on a transaction basis." We believe that the appropriate policy is to not require the disclosure of payments made to affiliates or subcontractors where the ERISA plan has paid the service provider a fixed fee directly for the service and the affiliate or subcontractor is not receiving a direct fee from the ERISA plan or an indirect fee from a third party.

BCBSA is concerned because a BCBS Plan typically charges a fixed per member per month fee to their ERISA plans customers for providing access to claims administration and networks of the other 38 BCBS plans. When an ERISA plan participant receives care in another state, the

BCBS plan in that state provides claims administration and network services as a subcontractor to the BCBS plan that directly contracts with the ERISA plan and covers the participant. BCBS Plans pay each other per-claim fees for providing these services to each other, but the per member per month fee charged to the ERISA plan is fixed and does not vary for the bundle of services provided by one BCBS Plan to another BCBS Plan. It will be very complex, if not impossible, for a BCBS Plan that has a contract with an ERISA plan and covers participants to disclose all of the per claim fees paid by it to any of 38 other BCBS Plans that may act as its subcontractor whenever a participant receives health care services outside of the Service Area of that Plan (i.e., his or her home state).

G. Conflict of Interest Disclosures

BCBSA Recommendation: The Department should eliminate the burdensome and vaguely defined conflict of interest disclosures mandated by paragraph (c)(1)(iii)(D) of the Proposed Regulation. ERISA already has sweeping prohibited transaction rules that bar conflict of interest transactions for plan fiduciaries and prohibit a number of otherwise arm's length transactions with service providers. These rules should be sufficient. Moreover, it is not clear why the disclosures of direct and indirect compensation required by the Proposed Regulation will not fully inform plan fiduciaries of potential conflicts.

The Proposed Regulation requires sweeping disclosures of potential conflicts of interest. These disclosure requirements are not clearly defined in the Proposed Regulation and will prevent service providers from relying with certainty on the relief offered under the section 408(b)(2) exemption. Such uncertainty would be detrimental for both plan sponsors and service providers as virtually all service arrangements rely on the section 408(b)(2) exemption.

In addition to the requirement to disclose direct and indirect compensation, the Proposed Regulation conditions relief under section 408(b)(2) on the service provider making a variety of conflict of interest disclosures. One particularly onerous requirement requires the disclosure of any material interest that "may create a conflict of interest for the service provider performing services under the contract." Prop. Reg. § 2550.408b-2(c)(1)(iii)(D). Service providers have not been given clear guidance on what "may" constitute a "material" conflict. Moreover, the Preamble to the Proposed Regulation suggests that whether information is "significant" and must be disclosed is a judgment made by a prudent plan fiduciary. 72 Fed. Reg. at 70992. This ambiguous standard will result in a great deal of uncertainty for service providers and inconsistent levels of disclosure between service providers. This will undermine any benefit that disclosure of this type may have for plan fiduciaries since the disclosure should be designed to produce useful comparative data among service providers.

This sweeping requirement would also mandate that service providers disclose relationships with other plan service providers. It may be nearly impossible for a service provider to comply with this requirement. For example, a TPA may provide services to an ERISA plan that also engages a consultant to perform actuarial services for the plan. The TPA may also serve as TPA for the consultant's own plan. This type of relationship would have to be disclosed in advance to all of the TPA's customers even though the TPA may have no way of knowing that the consultant

provided services to its client's plan. This "conflict" information may not be relevant to a plan fiduciary assessing the reasonableness of the TPA's services.

BCBSA Recommendation: The Department should eliminate the proposed new disclosure requirement related to the service provider affecting its own compensation or fees. Disclosure of legitimate compensation arrangements as a conflict of interest incorrectly suggests that receipt of such compensation by a service provider is inappropriate or illegal.

One of the many conflict of interest disclosures required under the Proposed Regulation is "whether the service provider (or an affiliate) will be able to affect its own compensation or fees, from whatever source, without the prior approval of an independent fiduciary." Prop. Reg. § 2550.408b-2(c)(1)(iii)(E). Many compensation arrangements where the service provider may in some fashion affect its own compensation are legitimate. For example, a TPA that performs enrollment services and is paid a per member per month fee might be viewed as a service provider that can affect its compensation since an effective enrollment program may result in more participants enrolling in employer provided health coverage. Similarly, a subrogation firm that is paid a fixed percentage of a recovery might be viewed as a service provider that can affect its compensation because the subrogation firm receives greater compensation the more effective it is in obtaining recoveries for its client ERISA plans.

Requiring service providers to identify this type of compensation in a conflict of interest disclosure suggests that these otherwise permissible arrangements are inappropriate. Calling mainstream compensation arrangements into question could severely hamper a fiduciary's willingness to enter into contractual arrangements and incent fiduciaries to consider compensation schemes that do not align the interests of the ERISA plan and the service provider (unlike the enrollment and subrogation examples above). Moreover, all of the compensation will have to be sufficiently disclosed to, and approved by the plan fiduciary in advance under the separate compensation and fees requirement, making this provision wholly unnecessary. The Department should eliminate this disclosure requirement.

H. Definition of Compensation

BCBSA Recommendation: The Department should narrow the definition of "compensation or fees" in the final rule so that compensation must be disclosed if the eligibility for payment or amount of payment is dependent on a transaction with an ERISA plan. It is particularly important to narrow the scope of compensation when applied to gifts and entertainment.

The Proposed Rule includes as reportable compensation "money *or any other thing* of monetary value (for example, gifts, awards, and trips)" received directly or indirectly from the plan, the plan sponsor *or any other source* in connection with the services to be provided under an arrangement for services or because of the service provider's or affiliate's position with the plan. Prop. Reg. § 2550.408b-2(c)(1)(iii)(A)(i) (emphasis added). This definition requires almost limitless disclosure that would overwhelm plan fiduciaries with information, including compensation information that is irrelevant to the plan and the services provided.

The definition of "compensation" in the Proposed Rule includes "gifts, awards and trips" received "in connection with the services to be provided pursuant to the contract or arrangement or because of the service provider's or affiliate's position with the plan" or because of the recipient's position with the plan. This is an inappropriate and impractical disclosure requirement.

In the recently finalized Schedule C guidance, the Department interpreted a similar definition by stating compensation will be deemed to be "money and any other thing of value... received by a person directly or indirectly, from the plan... in connection with services rendered to the plan, or the person's position with a plan" 72 Fed. Reg. at 64825. Based on this definition, disclosure of compensation on the revised Schedule C will be required if the person's eligibility for the compensation or the amount of the compensation is based on services rendered to the plan or transactions of the plan. This definition is better than the definition included in the Proposed Rule because it clearly ties the definition of disclosable compensation to amounts earned in connection with a plan transaction.

The Department should clarify the definition of compensation by including the following sentence in the Proposed Regulation: "Compensation will not be in connection with a plan services or a person's position with a plan unless the person's eligibility for the compensation (i.e., a right to the compensation) or the amount of the compensation is conditioned on services rendered to the plan or transactions of the plan." An example of the application of this rule would include where a plan fiduciary engages an insurance consultant to solicit insurance on the plan's behalf and that insurance consultant participates in a bonus program under which he or she may earn a trip to a resort by selling 10 new policies or contracts for the insurer. In that case, the consultant's right to the trip could be deemed compensation since it is based on plan transactions. In contrast, where a consultant attends a complimentary lunch hosted by the insurer and the insurer imposed no sales requirements as a condition of attendance, the value of that lunch should not be treated as compensation for purposes of the Proposed Regulation.

In addition, the Proposed Regulation requires disclosure of compensation before parties enter into a contract or arrangement for services. The Department should acknowledge that meal, gift and entertainment expenses cannot be accurately disclosed prior to entering into a service arrangement. If the Department has resolved to include meals and entertainment in the definition of compensation under the Proposed Regulation, it should allow service providers to satisfy this disclosure requirement by adopting and disclosing to plan fiduciaries a meals, gifts and entertainment expense policy rather than requiring disclosure that is unavoidably an inaccurate estimate with little value to plan fiduciaries.

I. Method of Providing Disclosure

BCBSA Recommendation: The Proposed Regulation requires on-going disclosure of material changes to each service provider's contract. These disclosure requirements create a costly perpetual disclosure obligation for service providers that may not be helpful to plan fiduciaries. The Department should confirm in the final regulation that disclosures need not be made together or in a particular form and may be made electronically by posting on a website.

The Proposed Regulation requires service providers to disclose any material change to the terms of the written agreement within 30 days of the date the service provider acquires knowledge of the material change. Prop. Reg. § 2550.408b-2(c)(1)(iv). The Preamble to the Proposed Regulation indicates that the required disclosures need not be made together or in any particular form and that a service provider may make disclosures electronically. 72 Fed. Reg. at 70990.

In order to limit the cost of and improve service provider efficiency in providing the disclosures required under the Proposed Regulation, in the text of the final regulation the Department should clarify that disclosures (both the fee disclosure and conflict of interest disclosure) can be delivered by posting the information on the service provider's website and providing specific directions to the plan fiduciary on how to access the information. This should apply for both initial and material change disclosures.

BCBSA Recommendation: The Department should provide certainty that disclosures of compensation via percentages, per participant charges and formulas will be deemed adequate under the Proposed Regulation.

The Proposed Regulation allows disclosure of "a monetary amount, formula, percentage of the plan's assets, or per capita charge for each participant or beneficiary" as long as the amount of compensation or fees is expressed in a manner that "contain[s] sufficient information to enable the responsible plan fiduciary to evaluate the reasonableness." Prop. Reg. § 2550.408b-2(c)(1)(A)(2).

BCBSA believes that allowing exact dollar disclosure based on a formula or estimate is appropriate, especially because, in some cases, disclosure of an exact dollar amount would not be possible or would be prohibitively expensive. However, BCBSA is concerned with the Proposed Regulation's standard, which suggests that the adequacy of the disclosure turns on each individual fiduciary's subjective evaluation. This will lead to inconsistent disclosures from plan to plan.

The Department should make clear that the standard is not a subjective standard based on whatever a particular fiduciary deems relevant. Developing a more objective standard would encourage consistency among disclosures and would prevent potential abuse by plan fiduciaries. Specifically, the Department should make clear that the disclosure of a percentage, formula, estimate or similar method will be deemed adequate where the disclosure "contains materially complete information disclosed in a clear and concise manner."

J. Eligible Indirect Compensation for Form 5500 Purposes

BCBSA Recommendation: The Department should clarify that the Proposed Regulation works in a consistent manner with the final Form 5500 Schedule C regulations.

BCBSA believes that the Department should clarify the application of the Form 5500 Schedule C regulation in the preamble to the final section 408(b)(2) regulation to ensure consistency between the related disclosure and reporting requirements. In particular, under the new Schedule C

requirements, certain indirect compensation paid to a service provider, including compensation paid on a per transaction basis, is afforded some streamlined reporting. Health plan service providers need to know if the type of indirect compensation they (or other parties in a bundled arrangement) receive qualifies as Eligible Indirect Compensation so that they can fashion their disclosures under the section 408(b)(2) regulation in a manner that will also allow the plan administrator to satisfy its requirements under the Form 5500 rule. As such, BCBSA asks that in the preamble to the final section 408(b)(2) regulations, the Department provide some examples of Eligible Indirect Compensation received in connection with common health plan arrangements.

For example, with respect to PBM services, the PBM may receive (1) drug rebates from drug manufacturers, (2) administrative fees for recordkeeping and administrative services provided to drug manufacturers in connection with rebate programs, and (3) a margin on drugs sold at pharmacies participating in the PBM's network. All of these payments should qualify as Eligible Indirect Compensation. In addition, the Department should clarify whether an arrangement under which a TPA offers recovery services through an affiliate or unaffiliated entity (e.g., subrogation or reimbursement services) and would retain a portion of the recovery by the subrogation firm should constitute Eligible Indirect Compensation.

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BCBSA appreciates the opportunity to provide these comments and would welcome the opportunity to meet with you to discuss them. I can be reached at 202.626.8651 or by e-mail at Jane.Galvin@bcbsa.com.

Sincerely,

Jane Galvin

Jane Galvin
Director
Regulatory Affairs