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Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfath under the Patient Protection and Affordable Care Act

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Table of Contents

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Parts 54 and 602
RIN 1545-BJ51
DEPARTMENT OF LABOR
Employee Benefits Security Administration
29 CFR Part 2590
RIN 1210-AB42
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OCIIO-9991-IFC
45 CFR Part 147
RIN 0991-AB68

AGENCIES:

Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Offi Information and Insurance Oversight, Department of Health and Human Services.

ACTION:

Interim final rules with request for comments.

SUMMARY:

This document contains interim final regulations implementing the rules for group health plans and health insurance coverage individual markets under provisions of the Patient Protection and Affordable Care Act regarding status as a grandfathered hea

DATES:

Effective Date: These interim final regulations are effective on June 14, 2010, except that the amendments to 26 CFR 54.981 2590.715-2714, and 45 CFR 147.120 are effective July 12, 2010.

Comment date. Comments are due on or before August 16, 2010.

ADDRESSES:

Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Departm the other Departments. Please do not submit duplicates.

All comments will be made available to the public. ***WARNING*** : Do not include any personally identifiable information (such as other contact information) or confidential business information that you do not want publicly disclosed. All comments are post

received, as they are public records. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN 1210-AB42, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Email*: *E-OHPSCA1251.EBSA@dol.gov*.
- *Mail or Hand Delivery*: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Adm 5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, *Attention*: RIN 1210-AB42.

Comments received by the Department of Labor will be posted without change to *http://www.regulations.gov* and *http://www.c* available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Consti Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code OCIIO-9991-IFC. Because of staff and r Departments cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instruction Search Options" tab.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Office of Consumer Information and
Insurance Oversight
Department of Health and Human
Services,
Attention: OCIIO-9991-IFC,
P.O. Box 8016,
Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Office of Consumer Information and
Insurance Oversight,
Department of Health and Human
Services,
Attention: OCIIO-9991-IFC,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comm the following addresses:

a. For delivery in Washington, DC—

Office of Consumer Information and
Insurance Oversight,
Department of Health and Human
Services,
Room 445-G, Hubert H. Humphrey
Building,
200 Independence Avenue, SW,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal govern commenters are encouraged to leave their comments in the OCIIO drop slots located in the main lobby of the building. A star for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid
Services,
Department of Health and Human
Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850

If you intend to deliver your comments to the Baltimore address, please call (410) 786-7195 in advance to schedule your arriv members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after tl

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requiremen instructions at the end of the "Collection of Information Requirements" section in this document.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by th personally identifiable or confidential business information that is included in a comment. The Departments post all comments close of the comment period on the following website as soon as possible after they have been received: *http://www.regulatio* search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Ba 21244, Monday through Friday of each week from 8:30 a.m. to 4:00 p.m. EST. To schedule an appointment to view public co 743-3951.

Internal Revenue Service. Comments to the IRS, identified by REG-118412-10, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail*: CC:PA:LPD:PR (REG-118412-10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station,
- *Hand or courier delivery*: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG-11 Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW, Washi to 4 p.m.

FOR FURTHER INFORMATION CONTACT:

Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin Service, Department of the Treasury, at (202) 622-6080; Jim Mayhew, Office of Consumer Information and Insurance Oversig Health and Human Services, at (410) 786-1565.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning emplo coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's website (*htt* In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Me website (*http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp*) and information on health reform can be fo *http://www.healthreform.gov*.

SUPPLEMENTARY INFORMATION

I. Background

The Patient Protection and Affordable Care Act (the Affordable Care Act), Pub. L. 111-148, was enacted on March 23, 2010; Education Reconciliation Act (the Reconciliation Act), Pub. L. 111-152, was enacted on March 30, 2010. The Affordable Care Reconciliation Act reorganize, amend, and add to the provisions in part A of title XXVII of the Public Health Service Act (PHS health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both ins group health plans.[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERIS (1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA a them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with g PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbe minor, changes. Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and sectio Reconciliation Act, specifies that certain plans or coverage existing as of the date of enactment (that is, grandfathered health to certain provisions.

The Affordable Care Act also adds section 715(a)(2) of ERISA, which provides that, to the extent that any provision of part 7 part A of title XXVII of the PHS Act with respect to group health plans or group health insurance coverage, the PHS Act provis the Affordable Care Act adds section 9815(a)(2) of the Code, which provides that, to the extent that any provision of subchap the Code conflicts with part A of title XXVII of the PHS Act with respect to group health plans or group health insurance cover provisions apply. Therefore, although ERISA section 715(a)(1) and Code section 9815(a)(1) incorporate by reference new pr affect preexisting sections of ERISA or the Code unless they cannot be read consistently with an incorporated provision of the ERISA section 732(a) generally provides that part 7 of ERISA — and Code section 9831(a) generally provides that chapter 1 not apply to plans with less than two participants who are current employees (including retiree-only plans that cover less than are current employees). Prior to enactment of the Affordable Care Act, the PHS Act had a parallel provision at section 2721(a Care Act amended, reorganized, and renumbered most of title XXVII of the PHS Act, that exception no longer exists. Similarly and (c) generally provides that the requirements of part 7 of ERISA — and Code section 9831(b) and (c) generally provides th chapter 100 of the Code — do not apply to excepted benefits.[2] Prior to enactment of the Affordable Care Act, the PHS Act h 2721(c) and (d) that indicated that the provisions of subparts 1 through 3 of part A of title XXVII of the PHS Act did not apply t After the Affordable Care Act amended and renumbered PHS Act section 2721(c) and (d) as section 2722(b) and (c), that exc be narrowed so that it applies only with respect to subpart 2 of part A of title XXVII of the PHS Act, thus, in effect requiring ex comply with subparts I and II of part A.

The absence of an express provision in part A of title XXVII of the PHS Act does not create a conflict with the relevant require Code. Accordingly, the exceptions of ERISA section 732 and Code section 9831 for very small plans and certain retiree-only excepted benefits, remain in effect and, thus, ERISA section 715 and Code section 9815, as added by the Affordable Care A plans or excepted benefits.

Moreover, there is no express indication in the legislative history of an intent to treat issuers of group health insurance covera governmental plans (that are subject to the PHS Act) any differently in this respect from plans subject to ERISA and the Code Health and Human Services, Labor, and the Treasury (the Departments) operate under a Memorandum of Understanding (M section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996, and sub and provides that requirements over which two or more Secretaries have responsibility ("shared provisions") must be adminis same effect at all times. HIPAA section 104 also requires the coordination of policies relating to enforcing the shared provisio duplication of enforcement efforts and to assign priorities in enforcement.

There is no express statement of intent that nonfederal governmental retiree-only plans should be treated differently from priv excepted benefits offered by nonfederal governmental plans should be treated differently from excepted benefits offered by p Because treating nonfederal governmental retiree-only plans and excepted benefits provided by nonfederal governmental pla create confusion with respect to the obligations of issuers that do not distinguish whether a group health plan is subject to ER in light of the MOU, the Department of Health and Human Services (HHS) does not intend to use its resources to enforce the or the Affordable Care Act with respect to nonfederal governmental retiree-only plans or with respect to excepted benefits pro governmental plans.

PHS Act section 2723(a)(2) (formerly section 2722(a)(2)) gives the States primary authority to enforce the PHS Act group and provisions over group and individual health insurance issuers. HHS enforces these provisions with respect to issuers only if it State has "failed to substantially enforce" one of the Federal provisions. Furthermore, the PHS Act preemption provisions allo requirements on issuers in the group and individual markets that are more protective than the Federal provisions. However, H States not to apply the provisions of title XXVII of the PHS Act to issuers of retiree-only plans or of excepted benefits. HHS ac do not apply these provisions to the issuers of retiree-only plans or of excepted benefits, HHS will not cite a State for failing to the provisions of part A of title XXVII of the PHS Act in these situations.

Subtitles A and C of title I of the Affordable Care Act amend the requirements of title XXVII of the PHS Act (changes to which ERISA section 715). The preemption provisions of ERISA section 731 and PHS Act section 2724[4] (implemented in 29 CFR 2 146.143(a)) apply so that the requirements of part 7 of ERISA and title XXVII of PHS Act, as amended by the Affordable Care "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requ to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such sta prevents the application of a requirement" of the Affordable Care Act. Accordingly, State laws that impose on health insurance that are stricter than the requirements imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

The Departments are issuing regulations implementing the revised PHS Act sections 2701 through 2719A in several phases. this series was a Request for Information relating to the medical loss ratio provisions of PHS Act section 2718, published in th April 14, 2010 (75 FR 19297). The second publication was interim final regulations implementing PHS Act section 2714 (requ coverage of children to age 26), published in the **Federal Register** on May 13, 2010 (T.D. 9482, 2010-22 I.R.B. 698 [75 FR 2 contains interim final regulations implementing section 1251 of the Affordable Care Act (relating to grandfathered health plans cross-reference to these interim final regulations in the regulations implementing PHS Act section 2714. The implementation PHS Act sections 2701 through 2719A will be addressed in future regulations.

II. Overview of the Regulations: Section 1251 of the Affordable Care Act, Preservation of Right to Maintain E CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140)

A. *Introduction*

Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Re provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (the date of enactment Act), are subject only to certain provisions of the Affordable Care Act. The statute and these interim final regulations refer to t insurance coverage as grandfathered health plans.

The Affordable Care Act balances the objective of preserving the ability of individuals to maintain their existing coverage with access to affordable essential coverage and improving the quality of coverage. Section 1251 provides that nothing in the Affo an individual to terminate the coverage in which the individual was enrolled on March 23, 2010. It also generally provides that health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, various requirements of the such plan or coverage, regardless of whether the individual renews such coverage after March 23, 2010. However, to ensure with certain particularly significant protections, Congress required grandfathered health plans to comply with a subset of the A health reform provisions. Thus, for example, grandfathered health plans must comply with the prohibition on rescissions of co case of fraud or intentional misrepresentation and the elimination of lifetime limits (both of which apply for plan years, or in the policy years, beginning on or after September 23, 2010). On the other hand, grandfathered health plans are not required to co requirements of the Affordable Care Act; for example, the requirement that preventive health services be covered without any otherwise becomes generally applicable for plan years, or in the individual market, policy years, beginning on or after Septem

A number of additional reforms apply for plan years (in the individual market, policy years) beginning on or after January 1, 20 requirements effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, grandf must then comply with some, but not all of these reforms. See Table 1 in section II.D of this preamble for a list of various requ grandfathered health plans.

In making grandfathered health plans subject to some but not all of the health reforms contained in the Affordable Care Act, th objective of preserving the ability to maintain existing coverage with the goals of expanding access to and improving the quali The statute does not, however, address at what point changes to a group health plan or health insurance coverage in which a enrolled on March 23, 2010 are significant enough to cause the plan or health insurance coverage to cease to be a grandfath leaving that question to be addressed by regulatory guidance.

These interim final regulations are designed to ease the transition of the healthcare industry into the reforms established by th by allowing for gradual implementation of reforms through a reasonable grandfathering rule. A more detailed description of th final regulations and other regulatory alternatives considered is included in section IV.B later in this preamble.

B. *Definition of Grandfathered Health Plan Coverage in Paragraph (a) of 26 CFR 54.9815-1251T, 29 CFR 2590 CFR 147.140 of these Interim Final Regulations*

Under the statute and these interim final regulations, a group health plan or group or individual health insurance coverage is a plan with respect to individuals enrolled on March 23, 2010. Paragraph (a)(1) of 26 CFR 54.9815-1251T, 29 CFR 2590.715-1 147.140 of these interim final regulations provides that a group health plan or group health insurance coverage does not ceas health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered

group health insurance coverage has continuously covered someone since March 23, 2010 (not necessarily the same persor one person). The determination under the rules of these interim final regulations is made separately with respect to each ben available under a group health plan or health insurance coverage.

Moreover, these interim final regulations provide that, subject to the rules of paragraph (f) of 26 CFR 54.9815-1251T, 29 CFR CFR 147.140 for collectively bargained plans, if an employer or employee organization enters into a new policy, certificate, or after March 23, 2010 (because, for example, any previous policy, certificate, or contract of insurance is not being renewed), th certificate, or contract of insurance is not a grandfathered health plan with respect to the individuals in the group health plan. group and individual health insurance markets to new entities or individuals after March 23, 2010 will not be grandfathered he health insurance products sold to those subscribers were offered in the group or individual market before March 23, 2010.

To maintain status as a grandfathered health plan, a plan or health insurance coverage (1) must include a statement, in any p to participants or beneficiaries (in the individual market, primary subscribers) describing the benefits provided under the plan coverage, that the plan or health insurance coverage believes that it is a grandfathered health plan within the meaning of sec Affordable Care Act and (2) must provide contact information for questions and complaints.

Model language is provided in these interim final regulations that can be used to satisfy this disclosure requirement. Commen possible improvements to the model language of grandfathered health plan status. Some have suggested, for example, that e health plan be required to list and describe the various consumer protections that do not apply to the plan or health insurance grandfathered, together with their effective dates. The Departments intend to consider any comments regarding possible impr language in the near term; any changes to the model language that may result from such comments could be published in ad guidance other than in the form of regulations.

Similarly, under these interim final regulations, to maintain status as a grandfathered health plan, a plan or issuer must also m documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010, and any other docume explain, or clarify its status as a grandfathered health plan. Such documents could include intervening and current plan docur policies, certificates or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverag required employee contribution rates. In addition, the plan or issuer must make such records available for examination. Accor beneficiary, individual policy subscriber, or State or Federal agency official would be able to inspect such documents to verify health insurance coverage as a grandfathered health plan. The plan or issuer must maintain such records and make them av for as long as the plan or issuer takes the position that the plan or health insurance coverage is a grandfathered health plan.

Under the statute and these interim final regulations, if family members of an individual who is enrolled in a grandfathered hea 2010 enroll in the plan after March 23, 2010, the plan or health insurance coverage is also a grandfathered health plan with re members.

C. *Adding New Employees in Paragraph (b) of 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 14 Final Regulations*

These interim final regulations at 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 provide that a group provided coverage on March 23, 2010 generally is also a grandfathered health plan with respect to new employees (whether enrolled) and their families who enroll in the grandfathered health plan after March 23, 2010. These interim final regulations c any health insurance coverage provided under the group health plan in which an individual was enrolled on March 23, 2010 is health plan. To prevent abuse, these interim final regulations provide that if the principal purpose of a merger, acquisition, or s restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plar to prevent grandfather status from being bought and sold as a commodity in commercial transactions. These interim final regu second anti-abuse rule designed to prevent a plan or issuer from circumventing the limits on changes that cause a plan or he to cease to be a grandfathered health plan under paragraph (g) (described more fully in section II.F of this preamble). This rul addresses a situation under which employees who previously were covered by a grandfathered health plan are transferred to health plan. This rule is intended to prevent efforts to retain grandfather status by indirectly making changes that would result those changes were made directly.

D. *Applicability of Part A of Title XXVII of the PHS Act to Grandfathered Health Plans Paragraphs (c), (d), and 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 of these Interim Final Regulations*

A grandfathered health plan generally is not subject to subtitles A and C of title I of the Affordable Care Act, except as specific statute and these interim final regulations. The statute and these interim final regulations provide that some provisions of subt the Affordable Care Act continue to apply to all grandfathered health plans and some provisions continue to apply only to gra that are group health plans. These interim final regulations clarify that a grandfathered health plan must continue to comply w the PHS Act, ERISA, and the Code that were applicable prior to the changes enacted by the Affordable Care Act, except to th

changes made by the Affordable Care Act. Therefore, the HIPAA portability and nondiscrimination requirements and the Gen Nondiscrimination Act requirements applicable prior to the effective date of the Affordable Care Act continue to apply to granc In addition, the mental health parity provisions, the Newborns' and Mothers' Health Protection Act provisions, the Women's H Act, and Michelle's Law continue to apply to grandfathered health plans. The following table lists the new health coverage ref XXVII of the PHS Act (as amended by the Affordable Care Act) that apply to grandfathered health plans:

TABLE 1.—*List of the New Health Reform Provisions of Part A of Title XXVII of the PHS Act that Apply to Grandfathe*

PHS Act Statutory Provisions	Application to Grandfathered Health Plans
§2704 Prohibition of preexisting condition exclusion or other discrimination based on health status	Applicable to grandfathered group health plans and group health ins Not applicable to grandfathered individual health insurance coverage
§2708 Prohibition on excessive waiting periods	Applicable
§2711 No lifetime or annual limits	Lifetime limits: Applicable Annual limits: Applicable to grandfathere and group health insurance coverage; not applicable to grandfathere insurance coverage.
§2712 Prohibition on rescissions	Applicable
§2714 Extension of dependent coverage until age 26	Applicable[a]
§2715 Development and utilization of uniform explanation of coverage documents and standardized definitions	Applicable
§2718 Bringing down cost of health care coverage (for insured coverage)	Applicable to insured grandfathered health plans.

[a] For a group health plan or group health insurance coverage that is a grandfathered health plan for plan years beginning be PHS Act section 2714 is applicable in the case of an adult child only if the adult child is not eligible for other employer-sponsc coverage. The interim final regulations relating to PHS Act section 2714, published in 75 FR 27122 (May 13, 2010), and thes regulations clarify that, in the case of an adult child who is eligible for coverage under the employer-sponsored plans of both plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the other parent's plan.

E. *Health Insurance Coverage Maintained Pursuant to a Collective Bargaining Agreement of Paragraph (f) of 1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 of these Interim Final Regulations*

In paragraph (f) of 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140, these interim final regulations prov health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 20 grandfathered health plan at least until the date on which the last agreement relating to the coverage that was in effect on Ma Thus, before the last of the applicable collective bargaining agreement terminates, any health insurance coverage provided p bargaining agreements is a grandfathered health plan, even if there is a change in issuers (or any other change described in CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 of these interim final regulations) during the period of the statutory language of the provision refers solely to "health insurance coverage" and does not refer to a group health plan; ther regulations apply this provision only to insured plans maintained pursuant to a collective bargaining agreement and not to sel date on which the last of the collective bargaining agreements terminates, the determination of whether health insurance cove pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of paragraph (g made by comparing the terms of the coverage on the date of determination with the terms of the coverage that were in effect change in issuers during the period of the agreement, by itself, would not cause the plan to cease to be a grandfathered healt of the agreement. However, for a change in issuers after the termination of the agreement, the rules of paragraph (a)(1)(ii) of 29 CFR 2590.715-1251, and 45 CFR 147.140 of these interim final regulations apply.

Similar language to section 1251(d) in related bills that were not enacted would have provided a delayed effective date for col plans with respect to the Affordable Care Act requirements. Questions have arisen as to whether section 1251(d) as enacted Act similarly operated to delay the application of the Affordable Care Act's requirements to collectively bargained plans — spe provision of section 1251(d) that exempts collectively bargained plans from requirements for the duration of the agreement ef plans with a delayed effective date with respect to all new PHS Act requirements (in contrast to the rules for grandfathered he that specified PHS Act provisions apply to all plans, including grandfathered health plans). However, the statutory language th collectively bargained plans, as signed into law as part of the Affordable Care Act, provides that insured collectively bargained individuals were enrolled on the date of enactment are included in the definition of a grandfathered health plan. Therefore, co plans (both insured and self-insured) that are grandfathered health plans are subject to the same requirements as other grand and are not provided with a delayed effective date for PHS Act provisions with which other grandfathered health plans must c provisions that apply to grandfathered health plans apply to collectively bargained plans before and after termination of the la collective bargaining agreement.

F. *Maintenance of Grandfather Status of Paragraph (g) of 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and*

these Interim Final Regulations)

Questions have arisen regarding the extent to which changes can be made to a plan or health insurance coverage and still ha considered the same as that in existence on March 23, 2010, so as to maintain status as a grandfathered health plan. Some change would cause a plan or health insurance coverage to be considered different and thus cease to be a grandfathered he suggested that any degree of change, no matter how large, is irrelevant provided the plan or health insurance coverage can t legal relationship to the plan or health insurance coverage that was in existence on March 23, 2010.

In paragraph (g)(1) of 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 of these interim final regulations set forth for determining when changes to the terms of a plan or health insurance coverage cause the plan or coverage to cea grandfathered health plan. The first of those rules (in paragraph (g)(1)(i)) constrains the extent to which the scope of benefits provides that the elimination of all or substantially all benefits to diagnose or treat a particular condition causes a plan or healt cease to be a grandfathered health plan. If, for example, a plan eliminates all benefits for cystic fibrosis, the plan ceases to be plan (even though this condition may affect relatively few individuals covered under the plan). Moreover, for purposes of para elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substa diagnose or treat a particular condition. An example in these interim final regulations illustrates that if a plan provides benefits health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates the plan is treated as having eliminated all or substantially all benefits for that mental health condition.

A second set of rules (in paragraphs (g)(1)(ii) through (g)(1)(iv)) limits the extent to which plans and issuers can increase the percentage cost-sharing requirements that are imposed with respect to individuals for covered items and services. Plans and make larger increases to fixed-amount or percentage cost-sharing requirements than permissible under these interim final reg point the individual's plan or health insurance coverage would cease to be grandfathered health plan coverage. A more detail basis for the cost-sharing requirements in these interim final regulations is included in section IV.B later in this preamble.

These interim final regulations provide different standards with respect to coinsurance and fixed-amount cost sharing. Coinsu rises with medical inflation. Therefore, changes to the *level* of coinsurance (such as moving from a requirement that the patie requirement that the patient pay 30 percent of inpatient surgery costs) would significantly alter the level of benefits provided. amount cost-sharing requirements (such as copayments and deductibles) do not take into account medical inflation. Therefor amount cost-sharing requirements (for example, moving from a $35 copayment to a $40 copayment for outpatient doctor visit keep up with the rising cost of medical items and services. Accordingly, paragraph (g)(1)(ii) provides that any increase in a pe requirement (such as coinsurance) causes a plan or health insurance coverage to cease to be a grandfathered health plan.

With respect to fixed-amount cost-sharing requirements, paragraph (g)(1)(iii) provides two rules: a rule for cost-sharing requir copayments and a rule for copayments. Fixed-amount cost-sharing requirements include, for example, a $500 deductible, a $ $2,500 out-of-pocket limit. With respect to fixed-amount cost-sharing requirements other than copayments, a plan or health in ceases to be a grandfathered health plan if there is an increase, since March 23, 2010, in a fixed-amount cost-sharing require than the maximum percentage increase. The maximum percentage increase is defined as medical inflation (from March 23, 2 percentage points. For this purpose, medical inflation is defined in these interim final regulations by reference to the overall m of the Consumer Price Index for All Urban Consumers, unadjusted (CPI), published by the Department of Labor. For fixed-am plan or health insurance coverage ceases to be a grandfathered health plan if there is an increase since March 23, 2010 in th exceeds the greater of (A) the maximum percentage increase or (B) five dollars increased by medical inflation. A more detaile basis for these rules relating to cost-sharing requirements is included in section IV.B later in this preamble.

With respect to employer contributions, these interim final regulations include a standard for changes that would result in cess status. Specifically, paragraph (g)(1)(v) limits the ability of an employer or employee organization to decrease its contribution a group health plan or group health insurance coverage. Two different situations are addressed. First, if the contribution rate i coverage, a group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer c decreases its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals[5] by more points below the contribution rate on March 23, 2010. For this purpose, contribution rate is defined as the amount of contribut employer or employee organization compared to the total cost of coverage, expressed as a percentage. These interim final re total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuat 604 of ERISA, section 4980B(f)(4) of the Code, and section 2204 of the PHS Act. In the case of a self-insured plan, contributi employee organization are calculated by subtracting the employee contributions towards the total cost of coverage from the t Second, if the contribution rate is based on a formula, such as hours worked or tons of coal mined, a group health plan or gro coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate t tier of coverage for any class of similarly situated individuals by more than 5 percent below the contribution rate on March 23,

Finally, paragraph (g)(1)(vi) addresses the imposition of a new or modified annual limit by a plan, or group or individual health Three different situations are addressed:

- A plan or health insurance coverage that, on March 23, 2010, did not impose an overall annual or lifetime limit on the benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual of benefits.

- A plan or health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of a annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.

- A plan or health insurance coverage that, on March 23, 2010, imposed an overall annual limit on the dollar value of all grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (rega plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all be

Under these interim final regulations, changes other than the changes described in 26 CFR 54.9815-1251T(g)(1), 29 CFR 25 45 CFR 147.140(g)(1) will not cause a plan or coverage to cease to be a grandfathered health plan. Examples include chang changes to comply with Federal or State legal requirements, changes to voluntarily comply with provisions of the Affordable C third party administrators, provided these changes are made without exceeding the standards established by paragraph (g)(1

These interim final regulations provide transitional rules for plans and issuers that made changes after the enactment of the A pursuant to a legally binding contract entered into prior to enactment, made changes to the terms of health insurance coverag before March 23, 2010 with a State insurance department, or made changes pursuant to written amendments to a plan that w March 23, 2010. If a plan or issuer makes changes in any of these situations, the changes are effectively considered part of th 23, 2010 even though they are not then effective. Therefore, such changes are not taken into account in considering whether insurance coverage remains a grandfathered health plan.

Because status as a grandfathered health plan under section 1251 of the Affordable Care Act is determined in relation to cov 2010, the date of enactment of the Affordable Care Act, the Departments considered whether they should provide a good faith from Departmental enforcement until guidance regarding the standards for maintaining grandfather status was made available health plans and health insurance issuers often make routine changes from year to year, and some plans and issuers may ha implement such changes prior to the issuance of these interim final regulations.

Accordingly, for purposes of enforcement, the Departments will take into account good-faith efforts to comply with a reasonab statutory requirements and may disregard changes to plan and policy terms that only modestly exceed those changes describ of 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 and that are adopted before June 14, 2010, the dat made publicly available.

In addition, these interim final regulations provide employers and issuers with a grace period within which to revoke or modify prior to June 14, 2010, where the changes might otherwise cause the plan or health insurance coverage to cease to be a gra Under this rule, grandfather status is preserved if the changes are revoked, and the plan or health insurance coverage is moc first day of the first plan or policy year beginning on or after September 23, 2010 to bring the terms within the limits for retainin these interim final regulations. For this purpose, and for purposes of the reasonable good faith standard changes will be cons adopted before these interim final regulations are publicly available if the changes are effective before that date, the changes that date pursuant to a legally binding contract entered into before that date, the changes are effective on or after that date pu that date with a State insurance department, or the changes are effective on or after that date pursuant to written amendment adopted before that date.

While the Departments have determined that the changes identified in paragraph (g)(1) of these interim final regulations woul plan or health insurance coverage to cease to be a grandfathered health plan, the Departments invite comments from the pub of changes is appropriate and what other changes, if any, should be added to this list. Specifically, the Departments invite co following changes should result in cessation of grandfathered health plan status for a plan or health insurance coverage: (1) c structure (such as switching from a health reimbursement arrangement to major medical coverage or from an insured product product); (2) changes in a network plan's provider network, and if so, what magnitude of changes would have to be made; (3) prescription drug formulary, and if so, what magnitude of changes would have to be made; or (4) any other substantial chang design. In addition, the Departments invite comments on the specific standards included in these interim final regulations on b and employer contributions. The Departments specifically invite comments on whether these standards should be drawn diffe that changes made by the Affordable Care Act may alter plan or issuer practices in the next several years. Any new standard regulations that are more restrictive than these interim final regulations would only apply prospectively to changes to plans or coverage after the publication of the final rules.

Moreover, the Departments may issue, as appropriate, additional administrative guidance other than in the form of regulations the rules contained in these interim final regulations for maintaining grandfathered health plan status prior to the issuance of f

response to these rules. This guidance can address unanticipated changes by plans and issuers to ensure that individuals be
Care Act's new health care protections while preserving the ability to maintain the coverage individuals had on the date of ena

III. Interim Final Regulations and Request for Comments

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury,
(collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisio
Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 thr
incorporation of those sections into ERISA section 715 and Code section 9815. The rules set forth in these interim final regula
applicability of the requirements in these sections and are therefore appropriate to carry them out. Therefore, the foregoing in
applies to these interim final regulations.

In addition, under Section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) a general notice of propos
required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or c
interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the s
by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. However, even if the APA were applica
have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these inter
place until a full public notice and comment process was completed. As noted above, numerous provisions of the Affordable C
for plan years (in the individual market, policy years) beginning on or after September 23, 2010, six months after date of enac
health plans are exempt from many of these provisions while group health plans and group and individual health insurance co
grandfathered health plans must comply with them. The determination of whether a plan or health insurance coverage is a gr
therefore could substantially affect the design of the plan or health insurance coverage.

The six-month period between the enactment of the Affordable Care Act and the applicability of many of the provisions affecte
would not allow sufficient time for the Departments to draft and publish proposed regulations, receive and consider comments
final regulations. Moreover, regulations are needed well in advance of the effective date of the requirements of the Affordable
health plans and health insurance coverage that are not grandfathered health plans must make significant changes in their pr
the requirements of the Affordable Care Act. Moreover, plans and issuers considering other modifications to their terms need
modifications will affect their status as grandfathered health plans. Accordingly, in order to allow plans and health insurance c
and implemented on a timely basis, regulations must be published and available to the public well in advance of the effective
requirements of the Affordable Care Act. It is not possible to have a full notice and comment process and to publish final regu
between enactment of the Affordable Care Act and the date regulations are needed.

The Secretaries further find that issuance of proposed regulations would not be sufficient because the provisions of the Afford
significant rights of plan participants and beneficiaries and individuals covered by individual health insurance policies and it is
participants, beneficiaries, insureds, plan sponsors, and issuers have certainty about their rights and responsibilities. Propose
binding and cannot provide the necessary certainty. By contrast, the interim final regulations provide the public with an opport
without delaying the effective date of the regulations.

For the foregoing reasons, the Departments have determined that it is impracticable and contrary to the public interest to eng
comment rulemaking before putting these regulations into effect, and that it is in the public interest to promulgate interim final

IV. Economic Impact and Paperwork Burden

A. *Overview-Department of Labor and Department of Health and Human Services*

As stated earlier in this preamble, these interim final regulations implement section 1251 of the Affordable Care Act, as modifi
the Affordable Care Act and section 2301 of the Reconciliation Act. Pursuant to section 1251, certain provisions of the Afforda
apply to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010 (a grandfath
statute and these interim final regulations allow family members of individuals already enrolled in a grandfathered health plan
after March 23, 2010; in such cases, the plan or coverage is also a grandfathered health plan with respect to the family memb
(whether newly hired or newly enrolled) and their families can enroll in a grandfathered group health plan after March 23, 201
status as a grandfathered health plan.[8]

As addressed earlier in this preamble, and further discussed below, these interim final regulations include rules for determinir
the terms of a grandfathered health plan made by issuers and plan sponsors allow the plan or health insurance coverage to r
health plan. These rules are the primary focus of this regulatory impact analysis.

The Departments have quantified the effects where possible and provided a qualitative discussion of the economic effects an
and costs that may result from these interim final regulations.

B. *Executive Order 12866—Department of Labor and Department of Health and Human Services*

Under Executive Order 12866 (58 FR 51735), "significant" regulatory actions are subject to review by the Office of Manageme
Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in a rule (1) havi
the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productiv
the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economical
creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially alte
impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising nov
arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determine
economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an annual eff
$100 million in any one year. Accordingly, OMB has reviewed these rules pursuant to the Executive Order. The Departments
of the potential costs, benefits, and transfers associated with these interim final regulations below. The Departments invite co
assessment and its conclusions.

1. *Need for Regulatory Action*

As discussed earlier in this preamble, Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordabl
2301 of the Reconciliation Act, provides that grandfathered health plans are subject only to certain provisions of the Affordabl
however, is silent regarding changes plan sponsors and issuers can make to plans and health insurance coverage while retai
These interim final regulations are necessary in order to provide rules that plan sponsors and issuers can use to determine w
make to the terms of the plan or health insurance coverage while retaining their grandfather status, thus exempting them from
the Affordable Care Act and fulfilling a goal of the legislation, which is to allow those that like their healthcare to keep it. These
regulations are designed to allow individuals who wish to maintain their current health insurance plan to do so, to reduce shor
market, and to ease the transition to market reforms that phase in over time.

In drafting this rule, the Departments attempted to balance a number of competing interests. For example, the Departments s
adequate flexibility to plan sponsors and issuers to ease transition and mitigate potential premium increases while avoiding ex
would conflict with the goal of permitting individuals who like their healthcare to keep it and might lead to longer term market s
least costly plans remain grandfathered the longest. In addition, the Departments recognized that many plan sponsors and iss
the terms of plans or health insurance coverage on an annual basis: premiums fluctuate, provider networks and drug formulai
and employee contributions and cost-sharing change, and covered items and services may vary. Without some ability to mak
while retaining grandfather status, the ability of individuals to maintain their current coverage would be frustrated, because mo
insurance coverage would quickly cease to be regarded as the same group health plan or health insurance coverage in existe
At the same time, allowing unfettered changes while retaining grandfather status would also be inconsistent with Congress's i
coverage that was in effect on March 23, 2010.

Therefore, as further discussed below, these interim final regulations are designed, among other things, to take into account r
routinely made by plan sponsors or issuers without the plan or health insurance coverage relinquishing its grandfather status
retain the ability to remain enrolled in the coverage in which they were enrolled on March 23, 2010. Thus, for example, these
generally permit plan sponsors and issuers to make voluntary changes to increase benefits, to conform to required legal char
voluntarily other consumer protections in the Affordable Care Act.

2. *Regulatory Alternatives*

Section 6(a)(3)(C)(iii) of Executive Order 12866 requires an economically significant regulation to include an assessment of th
potentially effective and reasonable alternatives to the planned regulation, and an explanation of why the planned regulatory a
the potential alternatives. The alternatives considered by the Departments fall into two general categories: permissible chang
benefits. The discussion below addresses the considered alternatives in each category.

The Departments considered allowing looser cost-sharing requirements, such as 25 percent plus medical inflation. However,
Departments to believe that the cost-sharing windows provided in these interim final regulations permit enough flexibility to er
in the group market over time, and further widening this window was not necessary and could conflict with the goal of allowing
healthcare to keep it.

Another alternative the Departments considered was an annual allowance for cost-sharing increases above medical inflation,
time allowance of 15 percent above medical inflation. An annual margin of 15 percent above medical inflation, for example, w
increase cost sharing by medical inflation plus 15 percent every year. The Departments concluded that the effect of the one-ti
percent of the original, date-of-enactment level plus medical inflation) would diminish over time insofar as it would represent a
the total level of cost sharing with the cumulative effects of medical inflation over time. Accordingly, the one-time allowance w
potential need of grandfathered health plans to make adjustments in the near term to reflect the requirement that they comply

that apply to grandfathered health plans in the near term as well as (ii) the prospect that, for many plans and health insurance recover the costs of compliance in other ways will diminish in the medium term, in part because of the changes that will becor in part because of the additional time plan sponsors and issuers will have to make gradual adjustments that take into account are due to take effect in later years.

The Departments considered establishing an overall prohibition against changes that, in the aggregate, or cumulatively over t coverage substantially different than the plan or coverage that existed on March 23, 2010, or further delineating other exampl cause a plan to relinquish grandfather status. This kind of "substantially different" standard would have captured significant ch the interim final regulation. However, it would rely on a "facts and circumstances" analysis in defining "substantially different" which would be less transparent and result in greater uncertainty about the status of a health plan. That, in turn, could hinder decisions as well as enrollee understanding of what protections apply to their coverage.

An actuarial equivalency standard was another considered option. Such a standard would allow a plan or health insurance co as a grandfathered health plan if the actuarial value of the coverage remains in approximately the same range as it was on M However, under such a standard, a plan could make fundamental changes to the benefit design, potentially conflicting with th who like their healthcare to keep it, and still retain grandfather status. Moreover, the complexity involved in defining and deter for these purposes, the likelihood of varying methodologies for determining such value unless the Departments promulgated prescriptive rules, and the costs of administering and ensuring compliance with such rules led the Departments to reject that a

Another alternative was a requirement that employers continue to contribute the same dollar amount they were contributing fo March 23, 2010, plus an inflation component. However, the Departments were concerned that this approach would not provid accommodate the year-to-year volatility in premiums that can result from changes in some plans' covered populations or othe

The Departments also considered whether a change in third party administrator by a self-insured plan should cause the plan status. The Departments decided that such a change would not necessarily cause the plan to be so different from the plan in 2010 that it should be required to relinquish grandfather status.

After careful consideration, the Departments opted against rules that would require a plan sponsor or issuer to relinquish its g relatively small changes are made to the plan. The Departments concluded that plan sponsors and issuers of grandfathered h permitted to take steps within the boundaries of the grandfather definition to control costs, including limited increases in cost-s changes not prohibited by these interim final regulations. As noted earlier, deciding to relinquish grandfather status is a one-w after some period of time, more plans will relinquish their grandfather status. These interim final regulations will likely influenc decisions to relinquish grandfather status.

3. *Discussion of Regulatory Provisions*

As discussed earlier in this preamble, these interim final regulations provide that a group health plan or health insurance cove considered a grandfathered health plan if a plan sponsor or an issuer:

- Eliminates all or substantially all benefits to diagnose or treat a particular condition. The elimination of benefits for any diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a parti
- Increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on March 23,
- Increases fixed-amount cost-sharing requirements other than copayments, such as a $500 deductible or a $2,500 out total percentage measured from March 23, 2010 that is more than the sum of medical inflation and 15 percentage poi
- Increases copayments by an amount that exceeds the greater of: a total percentage measured from March 23, 2010 t sum of medical inflation plus 15 percentage points, or $5 increased by medical inflation measured from March 23, 201
- For a group health plan or group health insurance coverage, an employer or employee organization decreases its con than five percentage points below the contribution rate on March 23, 2010; or
- With respect to annual limits (1) a group health plan, or group or individual health insurance coverage, that, on March impose an overall annual or lifetime limit on the dollar value of all benefits imposes an overall annual limit on the dolla group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall lifeti value of all benefits but no overall annual limit on the dollar value of all benefits adopts an overall annual limit at a doll than the dollar value of the lifetime limit on March 23, 2010; or (3) a group health plan, or group or individual health ins on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits decreases the dollar value of the

of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefi

Table 1, in section II.D of this preamble, lists the relevant Affordable Care Act provisions that apply to grandfathered health pl

In accordance with OMB Circular A-4,[10] Table 2 below depicts an accounting statement showing the Departments' assessm costs, and transfers associated with this regulatory action. In accordance with Executive Order 12866, the Departments belie this regulatory action justify the costs.

TABLE 2.—*Accounting Table*

Benefits Qualitative: These interim final regulations provide plans with guidance about the requirements for retaining grandf grandfathered plans are required to offer coverage with minimum benefit standards and patient protections as required by the while grandfathered plans are required only to comply with certain provisions. The existence of grandfathered health plans w with the benefits of plan continuity, which may have a high value to some. In addition, grandfathering could potentially slow th growth, depending on the extent to which their current plan does not include the benefits and protections of the new law. It co incentives to employers to continue coverage, potentially reducing new Medicaid enrollment and spending and lowering the r individuals. These interim final regulations also provide greater certainty for plans and issuers about what changes they can r their grandfather status. As compared with alternative approaches, these regulations provide significant economic and nonec issuers and beneficiaries, though these benefits cannot be quantified at this time.

Costs	Low-end Estimate	Mid-range Estimate	High-end Estimate	Year Dollar	Discount Rate
Annualized Monetized ($millions/year)	22.0	25.6	27.9	2010	7%
	21.2	24.7	26.9	2010	3%

Monetized costs are due to a requirement to notify participants and beneficiaries of a plan's grandfather status and maintain verify compliance with these interim final regulation's requirements to retain grandfather status.

Qualitative: Limitations on cost-sharing increases imposed by these interim final regulations could result in the cost of some plans increasing more (or decreasing less) than they otherwise would. This increased cost may encourage some sponsors a their grandfathered health plans with new, non-grandfathered ones. Market segmentation (adverse selection) due to the deci to relinquish grandfathering could cause premiums in the exchanges to be higher than they would have been absent grandfa

TransfersQualitative: Limits on the changes to cost-sharing in grandfathered plans and the elimination of cost-sharing for s grandfathered plans, leads to transfers of wealth from premium payers overall to individuals using covered services. Once pr are fully prohibited and other insurance reforms take effect, the extent to which individuals are enrolled in grandfathered plan selection, as higher risk plans relinquish grandfather status to gain new protections while lower risk grandfathered plans retai status. This could result in a transfer of wealth from non-grandfathered plans to grandfathered health plans.

4. Discussion of Economic Impacts of Retaining or Relinquishing Grandfather Status

The economic effects of these interim final regulations will depend on decisions by plan sponsors and issuers, as well as by t these plans and health insurance coverage. The collective decisions of plan sponsors and issuers over time can be viewed a process in which these parties decide whether, and when, to relinquish status as a grandfathered health plan.

Plan sponsors and issuers can decide to:

1. Continue offering the plan or coverage in effect on March 23, 2010 with limited changes, and thereby retain grandfath
2. Significantly change the terms of the plan or coverage and comply with Affordable Care Act provisions from which gra are excepted; or
3. In the case of a plan sponsor, cease to offer any plan.

For a plan sponsor or issuer, the potential economic impact of the application of the provisions in the Affordable Care Act ma in making its decisions. To determine the value of retaining the health plan's grandfather status, each plan sponsor or issuer the rules applicable to grandfathered health plans are more or less favorable than the rules applicable to non-grandfathered h determination will depend on such factors as the respective prices of grandfathered and non-grandfathered health plans, as v preferences of grandfathered health plans' covered populations and their willingness to pay for benefits and patient protectio grandfathered health plans. In making its decisions about grandfather status, a plan sponsor or issuer is also likely to conside (because different rules apply to the large and small group market segments), and the utilization pattern of its covered popula

In deciding whether to change a plan's benefits or cost sharing, a plan sponsor or issuer will examine its short-run business r

requirements are regularly altered by, among other things, rising costs that result from factors such as technological changes of the enrolled population, and changes in utilization and provider prices. As shown below, changes in benefits and cost shari insurance markets. Decisions about the extent of changes will determine whether a plan retains its grandfather status. Ultima involve a comparison by the plan sponsor or issuer of the long run value of grandfather status to the short-run need of that pla adjust plan structure in order to control premium costs or achieve other business objectives.

Decisions by plan sponsors and issuers may be significantly affected by the preferences and behavior of the enrollees, espec many towards inertia and resistance to change. There is limited research that has directly examined what drives this tendenc remain with health plans because of simple inertia and procrastination, a lack of relevant information, or because they want to with switching to new plans. One study that examined the extent to which premium changes influenced plan switching determ risk employees were the most price-sensitive to premium changes; older, high-risk employees were the least price-sensitive. that, in particular, individuals with substantial health needs may be more apt to remain with a plan because of inertia as such associated with plan switching rather than quality per se — a phenomenon some behavioral economists have called “status q be found when people stick with the status quo even though a change would have higher expected value.

Even when an enrollee could reap an economic or other advantage from changing plans, that enrollee may not make the cha a lack of relevant information, or because of the cost and effort involved in examining new options and uncertainty about the a with well-known findings in behavioral economics, studies of private insurance demonstrate the substantial effect of inertia in insured. One survey found that approximately 83 percent of privately insured individuals stuck with their plans in the year prio Among those who did change plans, well over half sought the same type of plan they had before. Those who switched plans reasons other than preferring their new plans. For example, many switched because they changed jobs or their employer cha offerings, compelling them to switch.

Medicare beneficiaries display similar plan loyalties. On average, only seven percent of the 17 million seniors on Medicare dr each year, according to the Centers for Medicare and Medicaid Services.[13] Researchers have found this comparatively low maintained whether or not those insured have higher quality information about plan choices, and that switching has little effec the insured with their health plans.[14]

The incentives to change are different for people insured in the individual market than they are for those covered by group he health insurance coverage. The median length of coverage for people entering the individual market is eight months.[15] In pa from the individual market’s function as a stopping place for people between jobs with employer-sponsored or other types of part, the churn is due to the behavior of issuers. Evidence suggests that issuers often make policy changes such as raising d of attracting new, healthy enrollees who have few medical costs and so are little-concerned about such deductibles. There is issuers use such changes to sort out high-cost enrollees from low-cost ones.[16]

Decisions about the value of retaining or relinquishing status as a grandfathered health plan are complex, and the wide array issuers, plan sponsors, and enrollees poses difficult challenges for the Departments as they try to estimate how large the pre health plans will be in the future and what the economic effects of their presence will be. As one example, these interim final r extent to which plan sponsors and issuers can increase cost sharing and still remain grandfathered. The increases that are al issuers with substantial flexibility in attempting to control expenditure increases. However, there are likely to be some plans a the absence of these regulations, choose to make even larger increases in cost sharing than are specified here. Such plans w whether the benefits of maintaining grandfather status outweigh those expected from increasing cost sharing above the level final regulations.

A similar analysis applies to the provision that an employer’s or employee organization’s share of the total premium of a grou reduced by more than 5 percentage points from the share it was paying on March 23, 2010 without that plan or health insurar relinquishing its grandfather status. Employers and employee organizations sponsoring group health plans or health insuranc faced with economic circumstances that would lead them to reduce their premium contributions. But reductions of greater tha would cause them to relinquish the grandfather status of their plans. These plan sponsors must decide whether the benefit of reductions outweigh those of retaining grandfather status.

Market dynamics affecting these decisions change in 2014, when the Affordable Care Act limits variation in premium rates for group policies. Small groups for this purpose include employers with up to 100 employees (States may limit this threshold to 5 2016). The Affordable Care Act rating rules will not apply to grandfathered health plans, but such plans will remain subject to vary widely and typically apply to employers with up to 50 employees. Based on the current State rating rules, it is likely that, rating rules will apply to group health insurance policies that are grandfathered health plans covering employers with 51 to 10

The interaction of the Affordable Care Act and State rating rules implies that, beginning in 2014, premiums can vary more wid plans than for non-grandfathered plans for employers with up to 100 employees in many States. This could encourage both p issuers to continue grandfathered health plans that cover lower-risk groups, because these groups will be isolated from the la grandfathered risk pool. On the other hand, this scenario likely will encourage plan sponsors and issuers that cover higher-ris

grandfathered health plans, because the group would be folded into the larger, lower-risk non-grandfathered pool. Depending grandfathered health plan market, such adverse selection by grandfathered health plans against non-grandfathered plans cou the exchanges to be higher than they would have been absent grandfathering. To accommodate these changes in market dy Departments have structured a cost-sharing rule whose parameters enable greater flexibility in early years and less over time plans will delay for many years before making changes that exceed medical inflation. This is because the cumulative increase March 23, 2010 is compared to a maximum percentage increase that includes a fixed amount — 15 percentage points — tha annually with any type of inflator. This should help mitigate adverse selection and require plans and issuers that seek to main to find ways other than increased copayments to limit cost growth. As discussed in the preamble, the Departments are also s make any adjustments needed for the final rule prior to 2014. Therefore it is premature to estimate the economic effects desc beyond. In the following section, the Departments provide a range of estimates of how issuers and sponsors might respond to regulations, with the caveat that there is substantial uncertainty about actual outcomes, especially considering that available d so do not account for behavioral changes in plans and the insured as a result of enactment of the Affordable Care Act.

5. *Estimates of Number of Plans and Employees Affected*

The Affordable Care Act applies to group health plans and health insurance issuers in the group and individual markets. The markets will be discussed first, followed by a discussion of impacts on the individual market. The Departments have defined *a* as a plan at an employer with 100 or more workers and a small group plan as a plan at an employer with less than 100 worke 2008 Medical Expenditure Survey — Insurance Component, the Departments estimated that there are approximately 72,000 health plans and 2.8 million small group health plans with an estimated 97.0 million participants and beneficiaries[18] in large g million participants and beneficiaries in small group plans. The Departments estimate that there are 126,000 governmental pl participants in large plans and 2.3 million participants in small plans. The Departments estimate there are 16.7 million individu covered by individually purchased policies.

a. *Methodology for analyzing plan changes over time in the group market*

For the large and small group markets, the Departments analyzed three years of Kaiser-HRET data to assess the changes th plan years 2007 to 2008 and 2008 to 2009. Specifically, the Departments examined changes made to deductibles, out-of-poc copayments, coinsurance, and the employer's share of the premium or cost of coverage. The Departments also estimated the plans that changed issuers.[20] The distribution of changes made within the two time periods were nearly identical and ultimat changes were used as a basis for the analyses.

As discussed previously, plans will need to make decisions that balance the value they (and their enrollees) place on maintai with the need to meet short run objectives by changing plan features including the various cost sharing requirements that are The 2008-2009 data reflect changes in plan benefit design that were made under very different market conditions and expect 2011 and beyond. Therefore, there is a significant degree of uncertainty associated with using the 2008-2009 data to project whose grandfather status may be affected in the next few years. Because the level of uncertainty becomes substantially grea this data to predict outcomes once the full range of reforms takes effect in 2014 and the exchanges begin operating, substant dynamics the Departments restrict our estimates to the 2011-2013 period and use the existing data and a range of assumptio outcomes based on a range of assumptions concerning how plans' behavior regarding cost sharing changes may change rel in the 2008-2009 data.

Deriving projections of the number of plans that could retain grandfather status under the requirements of these interim final r several steps:

- Using Kaiser/HRET data for 2008-2009, estimates were generated of the number of plans in the large and small grou changes in employer premium share or any of the cost-sharing parameters that were larger than permitted for a plan t status under these interim final regulations;

- In order to account for a range of uncertainty with regard to changes in plan behavior toward cost sharing changes, th assumed that many plans will want to maintain grandfather status and will look for ways to achieve short run cost cont that status. One plausible assumption is that plans would look to a broader range of cost sharing strategies in order to containment and other objectives than they had in the past. In order to examine this possibility, the Departments caref plans that would have relinquished grandfather status based on a change they made from 2008-2009. The Departmer proportion of these plans that could have achieved similar cost control by using one or more other cost-sharing chang they made in a manner that would not have exceeded the limits set by these interim final regulations for qualifying as plan. For example, if a plan was estimated to relinquish grandfather status because it increased its deductible by more percentage points plus medical inflation, the Departments analyze whether the plan could have achieved the same co with a smaller change in deductible, but larger changes (within the limits set forth in these interim final regulations) in c pocket maximums, and employer contributions to the premium or cost of coverage.

- Finally, the Departments examined the impact of alternative assumptions about sponsor behavior. For example, it is p sponsors who made changes from 2008-2009 in plan parameters that were so large that they would have relinquishe status would not make similar changes in 2011-2013. It is also possible that even though a sponsor could make an ec conforms to the rules established in these interim final regulations to maintain grandfather status, it would decide not t

The estimates in this example rely on several other assumptions. Among them: (1) the annual proportion of plans relinquishin the same throughout the period; (2) all group health plans existing at the beginning of 2010 qualify for grandfather status; (3) occur after March 23, 2010; (4) annual medical inflation is 4 percent (based on the average annual change in the medical CP 2009); and (5) firms for which the Kaiser-HRET survey has data for both 2008 and 2009 are representative of all firms.[21] The estimating the effects of the limits on copayment increases does not take into account the greater flexibility in the near term th estimated increase in firms losing their grandfather status over time reflects cumulative effects of a constant policy. To the ext plans that are more likely to make frequent changes in cost sharing, the assumption that a constant share of plans relinquishi throughout the period may underestimate the number of plans that will retain grandfather status through 2013. In addition, da changes were not available and thus not included in the analysis. The survey data is limited, in that it covers only one year of plans. The Departments' analysis employed data only on PPO plans, the predominant type of plan. In addition, the difficulties in response to this rule create uncertainties for quantitative evaluation. However, the analysis presented here is illustrative of balancing flexibility with maintaining current coverage.

b. *Impacts on the group market resulting from changes from 2008 to 2009*

The Departments first estimated the percentage of plans that had a percent change in the dollar value of deductibles, copaym maximums that exceeded 19 percent (the sum of medical inflation (assumed in these analyses to be four percent) plus 15 pe measured from March 23, 2010. Plans making copayment changes of five dollars or less were considered to have satisfied th if that change exceeded 19 percent.[22] The Departments also estimated the number of plans for whom the percentage of tota employer declined by more than 5 percentage points. For fully-insured plans only, estimates were made of the proportion that issuer.[23] This estimate does not take into account collectively bargained plans, which can change issuers during the period c bargaining agreement without a loss of grandfather status, because the Departments could not quantify this category of plans estimate represents an upper bound.

Using the Kaiser/HRET data, the Departments estimated that 55 percent of small employers and 36 percent of large employe change in cost-sharing parameters above the thresholds provided in these interim final regulations. Similarly, 33 percent of sr percent of large employers decreased the employer's share of premium by more than five percentage points. In total, approxi small employers and 48 percent of large employers made a change in either cost sharing or premium contribution during 200 them to relinquish grandfather status if the same change were made in 2011.[24]

The changes made by employers from 2008 to 2009 were possibly made in anticipation of the recession. As discussed previc changes from 2007 to 2008 suggests that the 2007-08 changes were not much different from the 2008-09 changes. Neverthe improvements in economic conditions, it makes sense to think that the pressure on employers to reduce their contributions to smaller in 2011 than they were in 2009, and that the Department's analysis of changes in 2009 may overestimate the change expected in 2011.[25]

As discussed previously, it is highly unlikely that plans would continue to exhibit the same behavior in 2011 to 2013 as in 200 guide the choice of behavioral assumptions, the Departments conducted further analyses of the 2008-2009 data. Many emplc changes between 2008 and 2009 that would have caused them to relinquish grandfather status did so based on exceeding o limits. Assuming that the sponsor's major objective in implementing these changes was to restrain employer costs or overall p Departments examined whether the sponsor could have achieved the same net effect on employer cost or premiums by spre two or more changes without exceeding the limits on any of these changes. For example, an employer that increased its dedu would have relinquished grandfather status. However, it is possible that the employer could have achieved the same cost cor limiting the deductible increase to 19 percent, and, also increasing the out-of-pocket maximum or copayments, or decreasing the premium.

The Departments estimate that approximately two-thirds of the employers that made changes in 2009 that would have excee implemented by this rule could have achieved the same cost-control objective and remained grandfathered by making change parameters or in the employer share of the premium. Only 24 percent of small employers and 16 percent of large employers c reconfigured the cost-sharing parameters or employer contributions in such a manner that would have allowed them to stay g changes that are allowed within the grandfathered health plan definition were also taken into account (not possible with availa percentages would be even lower.

For fully insured group health plans, another change that would require a plan to relinquish grandfather status is a change in i and 2009, 15 percent of small employers and four percent of large employers changed insurance carriers.[26] However, it is lil stay grandfathered would lead some of these employers to continue with the same issuer, making the actual share of firms re

status as a result of an issuer change lower than the percentage that switched in 2009. There appears to be no empirical evic guidance on the proportion of employers that would choose to remain with their issuer rather than relinquish grandfather statu assumption was made that 50 percent of employers that changed issuers in 2009 would not have made a similar change in 2 grandfather status. It is likely that fewer employers will elect to change carriers than in recent years given that some will prefe status. But it is also likely that many employers will prefer to switch carriers given a change in the issuer's network or other fa little empirical evidence regarding the fraction of firms that would elect to switch in response to the change in regulations, we plausible range of no switching carriers at one extreme and all switching carriers at the other extreme. We therefore assume employers that changed issuers in 2009 would not make a similar change in 2011 to retain grandfather status.

Combining the estimates of the percentage of employers that would relinquish grandfather status because they chose to mak or employer contribution changes beyond the permitted parameters with the estimates of the percentage that would relinquisl because they change issuers, the Departments estimate that approximately 31 percent of small employers and 18 percent of make changes that would require them to relinquish grandfather status in 2011. The Departments use these estimates as our

c. *Sensitivity analysis: assuming that employers will be willing to absorb a premium increase in order to ren*

To the extent that a large number of plans placed a high value on remaining grandfathered, it is reasonable to assume that sc other measures to maintain that status. In addition to the adjustments that employers could relatively easily make by simply a cost-sharing parameters rather than focusing changes on a single parameter, the Departments expect that further behavioral the incentives created by the Affordable Care Act and these interim final regulations is possible. For instance, plans could alte decide to accept a slight increase in plan premium or in premium contribution. All of these options would further lower the per would relinquish grandfather status. There is substantial uncertainty, however, about how many firms would utilize these othe

To examine the impact of this type of behavior on the estimates on the number of plans that would not maintain grandfather s examined the magnitude of additional premium increases plans would need to implement if they were to modify their cost-sha within the allowable limits. Among the 24 percent of small firms that would have relinquished grandfather status based on the 2009, 31 percent would have needed to increase premiums by 3 percent or less in order to maintain grandfather status. The a the 16 percent of large firms that would have relinquished grandfather status is 41 percent. It is reasonable to think that emplo only a relatively small premium increase might choose to remain grandfathered.

Using these estimates, if employers value grandfathering enough that they are willing to allow premiums to increase by three otherwise intended level (or can make changes to benefits other than cost-sharing that achieve a similar result), then 14 perc and 11 percent of large employers would relinquish grandfather status if they made the same changes in 2011 as they had in employers who would relinquish grandfather status because they change issuers, the Departments' lower bound estimate is t percent of small employers and 13 percentof large employers will relinquish grandfather status in 2011.

d. *Sensitivity analysis: incomplete flexibility to substitute one cost-sharing mechanism for another*

Although economic conditions may cause more plans to remain grandfathered in 2011 than might be expected from analysis are other factors that may cause the Departments' estimates of the fraction of plans retaining grandfather status to be overes that will retain grandfather status. The estimates are based on the assumption that all plans that could accommodate the 200 a single cost-sharing parameter by spreading out those changes over multiple parameters would actually do so. However, so may be concerned about the labor relations consequences of reducing the employer contribution to premium. For example, if of-pocket maximum from $3,000 to $5,000 in 2009, it could choose to remain grandfathered by limiting the out-of-pocket max reducing the employer contribution and increasing the employee contribution to premium. It is not clear, however, that all plar — some may see the costs in negative employee relations as larger than the benefits from remaining grandfathered. Moreov may already nearly comply with all provisions of the Affordable Care Act, or because enrollees are of average to less favorab employers may place less value on retaining grandfather status.

With this in mind, the Departments replicated the analysis, but assumed that one-half of the employers who made a change i parameter that could not be accommodated without reducing the employer contribution will be unwilling to reduce the employ share of premium. Under this assumption, the 24 percent and 16 percent estimates of the proportion of employers relinquishi increases to approximately 37 percent and 28 percent among small and large employers, respectively. Adding in the number estimated will change issuers, the Departments' high-end estimate for the proportion that will relinquish grandfather status in 42 percent for small employers and 29 percent for large employers.

e. *Estimates for 2011-2013*

Estimates are provided above for the percentage of employers that will retain grandfather status in 2011. These estimates are 2013 by assuming that the identical percentage of plan sponsors will relinquish grandfathering in each year. Again, to the exte

data reflect plans that are more likely to make frequent changes in cost sharing, this assumption will overestimate the numbe grandfather status in 2012 and 2013.

Under this assumption, the Departments' mid-range estimate is that 66 percent of small employer plans and 45 percent of lar relinquish their grandfather status by the end of 2013. The low-end estimates are for 49 percent and 34 percent of small and respectively, to have relinquished grandfather status, and the high-end estimates are 80 percent and 64 percent, respectively

TABLE 3.—*Estimates of the Cumulative Percentage of Employer Plans Relinquishing Their Grandfathered St*		
	2011	2012
Low-end Estimate		
Small Employer Plans	20%	36%
Large Employer Plans	13%	24%
All Employer Plans	**15%**	**28%**
Mid-range Estimate		
Small Employer Plans	30%	51%
Large Employer Plans	18%	33%
All Employer Plans	**22%**	**38%**
High-end Estimate		
Small Employer Plans	42%	66%
Large Employer Plans	29%	50%
All Employer Plans	**33%**	**55%**
Notes: Represents full-time employees. Small Employers=3 to 99 employees; Large Employers=100+ employees. All three s two percent of all large employer plans and six percent of small employer plans would relinquish grandfathered status due to Estimates are based on enrollment in PPOs. Source: Kaiser/RHET Employer Survey, 2008-2009		

f. *Impacts on the Individual Market*

The market for individual insurance is significantly different than that for group coverage. This affects estimates of the proport remain grandfathered until 2014. As mentioned previously, the individual market is a residual market for those who need insu group coverage available and do not qualify for public coverage. For many, the market is transitional, providing a bridge betw coverage. One study found a high percentage of individual insurance policies began and ended with employer-sponsored cov importantly, coverage on particular policies tends to be for short periods of time. Reliable data are scant, but a variety of studi 40 percent and 67 percent of policies are in effect for less than one year.[28] Although data on changes in benefit packages co group market is not readily available, the high turnover rates described here would dominate benefit changes as the chief sou grandfather status.

While a substantial fraction of individual policies are in force for less than one year, a small group of individuals maintain their time periods. One study found that 17 percent of individuals maintained their policies for more than two years,[29] while anothe percent maintained policies for more than three years.[30]

Using these turnover estimates, a reasonable range for the percentage of individual policies that would terminate, and therefo grandfather status, is 40 percent to 67 percent. These estimates assume that the policies that terminate are replaced by new that these new policies are not, by definition, grandfathered. In addition, the coverage that some individuals maintain for long grandfather status because the cost-sharing parameters in policies change by more than the limits specified in these interim f frequency of this outcome cannot be gauged due to lack of data, but as a result of it, the Departments estimate that the perce market policies losing grandfather status in a given year exceeds the 40 percent to 67 percent range that is estimated based individual policies that turn over from one year to the next.

g. *Application to extension of dependent coverage to age 26*

One way to assess the impact of these interim final regulations is to assess how they interact with other Affordable Care Act p provision is the requirement that, in plan years on or after September 23, 2010, but prior to January 1, 2014, grandfathered gr required to offer dependent coverage to a child under the age of 26 who is not eligible for employer-sponsored insurance. In t Assessment (RIA) for the regulation that was issued on May 13, 2010 (75 FR 27122), the Departments estimated that there w adults age 19-25 who were covered by employer-sponsored coverage (ESI) and whose parents were covered by employer-s and an additional 480,000 young adults who were uninsured, were offered ESI, and whose parents were covered by ESI. In t

the Departments assumed that all parents with employer-sponsored insurance would be in grandfathered health plans, and th year old dependents with their own offer of employer-sponsored insurance would gain coverage as a result of that regulation.

As estimated here, approximately 80 percent of the parents with ESI are likely to be in grandfathered health plans in 2011, lea percent of these parents in non-grandfathered health plans. Young adults under 26 with employer-sponsored insurance or wi coverage whose parents are in non-grandfathered plans potentially could enroll in their parents' coverage. The Departments a percentage of the young adults who are uninsured will enroll in their parents' coverage when given the opportunity. It is more choices of young adults with an offer of employer-sponsored insurance whose parents also have group coverage. One assun will compare the amount that they must pay for their own employer's coverage with the amount that they (or their parents) wo covered under their parents' policies. Such a decision will incorporate the type of plan that the parent has, since if the parent a plan whose premium does not vary by number of dependents, the adult child could switch at no additional cost to the parents therefore is that approximately 25 percent of young adults with ESI will switch to their parents' coverage when their parents' c grandfathered. The Departments assume that 15 percent of young adults who are offered ESI but are uninsured and whose p grandfathered health plans will switch to their parents' plan. This latter estimate roughly corresponds to the assumption made scenario in the RIA for dependent coverage for young adults who are uninsured.

These assumptions imply that an additional approximately 414,000 young adults whose parents have non-grandfathered ESI parents' health coverage in 2011, of whom 14,000 would have been uninsured, compared with the dependent coverage regul that assumed that all existing plans would have remained grandfathered and none of these adult children would have been el under their parents' plans. By 2013, an estimated 698,000 additional young adults with ESI or an offer of ESI will be covered grandfathered health policy, of which 36,000 would have been uninsured.

6. *Grandfathered Health Plan Document Retention and Disclosure Requirements*

To maintain grandfathered health plan status under these interim final regulations, a plan or issuer must maintain records tha policy terms in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, expla a grandfathered health plan. The records must be made available for examination by participants, beneficiaries, individual pol State or Federal agency official.

Plans or health insurance coverage that intend to be a grandfathered health plan, also must include a statement, in any plan participants or beneficiaries (in the individual market, primary subscriber) describing the benefits provided under the plan or h coverage, and that the plan or coverage is intended to be a grandfathered health plan within the meaning of section 1251 of t In these interim final regulations, the Departments provide a model statement plans and issuers may use to satisfy the disclos Department's estimate that the one time cost to plans and insurance issuers of preparing and distributing the grandfathered h $39.6 million in 2011. The one time cost to plans and insurance issuers for the record retention requirement is estimated to be For a discussion of the grandfathered health plan document retention and disclosure requirements, see the Paperwork Reduc this preamble.

C. *Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services*

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to federal rules that are and comment requirements of section 553(b) of the APA (5 U.S.C. 551 *et seq.*) and that are likely to have a significant econo substantial number of small entities. Under Section 553(b) of the APA, a general notice of proposed rulemaking is not require good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. T regulations are exempt from the APA, because the Departments made a good cause finding that a general notice of propose necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments are not required to either certify t would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analy

Nevertheless, the Departments carefully considered the likely impact of the regulations on small entities in connection with th Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments tha rules that accomplish the stated purpose of section 1251 of the Affordable Care Act and minimize the impact on small entities

D. *Special Analyses-Department of the Treasury*

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executiv Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Proc chapter 5) does not apply to these regulations. For the applicability of the RFA, refer to the Special Analyses section in the pr referencing notice of proposed rulemaking published elsewhere in this issue of the Bulletin. Pursuant to section 7805(f) of the regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on the

businesses.

E. *Paperwork Reduction Act*

1. *Department of Labor and Department of Treasury: Affordable Care Act Grandfathered Plan Disclosure and Requirements*

As part of their continuing efforts to reduce paperwork and respondent burden, the Departments conduct a preclearance cons provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of inf with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)). This helps to ensure that requested data can be format, reporting burden (time and financial resources) is minimized, collection requirements on respondents can be properly

As discussed earlier in this preamble, if a plan or health insurance coverage intends to be a grandfathered health plan, it mus any plan materials provided to participants or beneficiaries (in the individual market, primary subscriber) describing the benefi plan or health insurance coverage, and that the plan or coverage is intended to be grandfathered health plan within the mean the Affordable Care Act ("grandfathered health plan disclosure"). Model language has been provided in these interim final reg which will satisfy this disclosure requirement

To maintain status as a grandfathered health plan under these interim final regulations, a plan or issuer must maintain record or policy terms in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, ex as a grandfathered health plan ("recordkeeping requirement"). In addition, the plan or issuer must make such records availab Accordingly, a participant, beneficiary, individual policy subscriber, or State or Federal agency official would be able to inspec verify the status of the plan or health insurance coverage as a grandfathered health plan.

As discussed earlier in this preamble, grandfathered health plans are not required to comply with certain Affordable Care Act interim regulations define for plans and issuers the scope of changes that they can make to their grandfathered health plans a Affordable Care Act while retaining their grandfathered health plan status.

The Affordable Care Act grandfathered health plan disclosure and recordkeeping requirements are information collection requ the PRA. Currently, the Departments are soliciting public comments for 60 days concerning these disclosures. The Departme copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of t assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of approp electronic, mechanical, or other technological collection techniques or other forms of information technology, for exam electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benef Administration either by fax to (202)395-7285 or by email to *oira_submission@omb.eop.gov*. A copy of the ICR may be obtai PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Securit Constitution Avenue, NW, Room N-5718, Washington, DC 20210. Telephone: (202) 693-8410; Fax: (202) 219-2745. These a E-mail: *ebsa.opr@dol.gov*. ICRs submitted to OMB also are available at reginfo.gov (*http://www.reginfo.gov/public/do/PRAMa*

a. Grandfathered health plan disclosure

In order to satisfy the interim final regulations' grandfathered health plan disclosure requirement, the Departments estimate th covered plans will need to notify an estimated 56.3 million policy holders of their plans' grandfathered health plan status.[31] T except where noted, are based on the mid-range estimates of the percent of plans retaining grandfather status. Because the provide model language for this purpose, the Departments estimate that five minutes of clerical time (with a labor rate of $26. to incorporate the required language into the plan document and ten minutes of an human resource professional's time (with

2011, any additional burden should be *de minimis* if a plan wants to maintain its grandfather status in future years. The Depa cost of removing the notice from plan documents as plans relinquish their grandfather status to be *de minimis* and therefore is Therefore, the Departments estimate that plans will incur a one-time hour burden of 538,000 hours with an equivalent cost of the disclosure requirement.

The Departments assume that only printing and material costs are associated with the disclosure requirement, because the ir provide model language that can be incorporated into existing plan documents, such as a summary plan description (SPD). T estimate that the notice will require one-half of a page, five cents per page printing and material cost will be incurred, and 38 p will be delivered electronically. This results in a cost burden of $873,000 ($0.05 per page*1/2 pages per notice * 34.9 million r

b. Record-Keeping requirement

The Departments assume that most of the documents required to be retained to satisfy recordkeeping requirement of these ir already are retained by plans for tax purposes, to satisfy ERISA's record retention and statute of limitations requirements, and reasons. Therefore, the Departments estimate that the recordkeeping burden imposed by this ICR will require five minutes of time (with a rate of $119.03/hour) to determine the relevant plan documents that must be retained and ten minutes of clerical rate of $26.14/hour) to organize and file the required documents to ensure that they are accessible to participants, beneficiari State governmental agency officials.

With an estimated 2.2 million grandfathered plans in 2011, the Departments estimate an hour burden of approximately 538,0(costs of $30.7 million. The Departments have estimated this as a one-time cost incurred in 2011, because after the first year, anticipate that any future costs will be *de minimis*.

Overall, for both the grandfathering notice and the recordkeeping requirement, the Departments expect there to be a total hou hours and a cost burden of $291,000.

The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to c unless the ICR has a valid OMB control number.

These paperwork burden estimates are summarized as follows:

Type of Review: New Collection

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of Tr

Title: Disclosure and Recordkeeping Requirements for Grandfathered Health Plans under the Affordable Care Act.

OMB Number: 1210-0140; 1545-2178

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 2,151,000.

Total Responses: 56,347,000.

Frequency of Response: One time

Estimated Total Annual Burden Hours: 538,000 (Employee Benefits Security Administration); 538,000 (Internal Revenue Serv

Estimated Total Annual Burden Cost: $437,000 (Employee Benefits Security Administration); $437,000 (Internal Revenue Se

2. Department of Health and Human Services: Affordable Care Act Grandfathered Plan Disclosure and Recor Requirements

As discussed above in the Department of Labor and Department of the Treasury PRA section, these interim final regulations retention and disclosure requirement for grandfathered health plans. These requirements are information collection requireme

a. Grandfathered health plan disclosure

In order to satisfy the interim final regulations' grandfathered health plan disclosure requirement, the Department estimates th local governmental plans will need to notify approximately 16.2 million policy holders of their plans' status as a grandfathered following estimates except where noted are based on the mid-range estimates of the percent of plans retaining grandfather st insurers providing coverage in the individual market will need to notify an estimated 4.3 million policy holders of their policies' grandfathered health plan.[33]

Because the interim final regulations provide model language for this purpose, the Department estimates that five minute of c rate of $26.14/hour) will be required to incorporate the required language into the plan document and ten minutes of a human time (with a labor rate of $89.12/hour) will be required to review the modified language.[34] After plans first satisfy the grandfat disclosure requirement in 2011, any additional burden should be *de minimis* if a plan wants to maintain its grandfather status Department also expects the cost of removing the notice from plan documents as plans relinquish their grandfather status to therefore is not estimated. Therefore, the Department estimates that plans and insurers will incur a one-time hour burden of 2 equivalent cost of $1.8 million to meet the disclosure requirement.

The Department assumes that only printing and material costs are associated with the disclosure requirement, because the ir provide model language that can be incorporated into existing plan documents, such as an SPD. The Department estimates t require one-half of a page, five cents per page printing and material cost will be incurred, and 38 percent of the notices will be This results in a cost burden of $318,000 ($0.05 per page*1/2 pages per notice * 12.7 million notices*0.62).

b. Record-Keeping requirement

The Department assumes that most of the documents required to be retained to satisfy the Affordable Care Act's recordkeepi are retained by plans for tax purpose, to satisfy ERISA's record retention and statute of limitations requirements, and for othe Therefore, the Department estimates that the recordkeeping burden imposed by this ICR will require five minutes of a legal pr rate of $119.03/hour) to determine the relevant plan documents that must be retained and ten minutes of clerical staff time (w $26.14/hour) to organize and file the required documents to ensure that they are accessible to participants, beneficiaries, and governmental agency officials.

With an estimated 98,000 grandfathered plans and 7,400 grandfathered individual insurance products[35] in 2011, the Departr burden of approximately 26,000 hours with equivalent costs of $1.5 million. The Department's have estimated this as a one-ti 2011, because after the first year, the Department assumes any future costs will be *de minimis*.

Overall, for both the grandfathering notice and the recordkeeping requirement, the Department expects there to be a total hou hours and a cost burden of $318,000.

The Department notes that persons are not required to respond to, and generally are not subject to any penalty for failing to c unless the ICR has a valid OMB control number.

These paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agency: Department of Health and Human Services.

Title: Disclosure and Recordkeeping Requirements for Grandfathered Health Plans under the Affordable Care Act.

OMB Number: 0938-1093.

Affected Public: Business; State, Local, or Tribal Governments.

Respondents: 105,000.

Responses: 20,508,000.

Frequency of Response: One-time.

Estimated Total Annual Burden Hours: 53,000 hours.

Estimated Total Annual Burden Cost: $318,000.

If you comment on this information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: OCIIO Desk Officer, OCIIO-9991-IFC

Fax: (202) 395-6974; or

Email: *OIRA_submission@omb.eop.gov*

F. *Congressional Review Act*

These interim final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enfo 1996 (5 U.S.C. 801 et seq.) and have been transmitted to Congress and the Comptroller General for review.

G. *Unfunded Mandates Reform Act*

The Unfunded Mandates Reform Act of 1995 (Public Law 104-4) requires agencies to prepare several analytic statements be that may result in annual expenditures of $100 million (as adjusted for inflation) by State, local and tribal governments or the p interim final regulations are not subject to the Unfunded Mandates Reform Act, because they are being issued as an interim f However, consistent with the policy embodied in the Unfunded Mandates Reform Act, these interim final regulations have bee least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of

H. *Federalism Statement—Department of Labor and Department of Health and Human Services*

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by federa process of their formulation and implementation of policies that have ''substantial direct effects'' on the States, the relationshi government and States, or on the distribution of power and responsibilities among the various levels of government. Federal regulations that have these federalism implications must consult with State and local officials, and describe the extent of their nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, this regulation has federalism implications, because it has direct effects on the States, the relations government and States, or on the distribution of power and responsibilities among various levels of government. However, in the federalism implications of the regulation is substantially mitigated because, with respect to health insurance issuers, the D the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the federal stand

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insuranc company or bank, the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590. 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be ''construed to su State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insuranc with group health insurance coverage except to the extent that such standard or requirement prevents the application of a rec standard. The conference report accompanying HIPAA indicates that this is intended to be the ''narrowest'' preemption of Sta Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply Stat except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subje State insurance laws that are more stringent than the federal requirements are unlikely to ''prevent the application of'' the Affo preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more re law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have feder limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperative and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting wi

officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care
Throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HI
Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers,
provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have co
requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these regula
certify that the Employee Benefits Security Administration and the Office of Consumer Information and Insurance Oversight h
requirements of Executive Order 13132 for the attached regulation in a meaningful and timely manner.

V. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and

The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1
1181-1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104-191, 110 Stat. 1936; s
200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L.
as amended by Pub. L. 111-152, 124 Stat. 1029; Secretary of Labor's Order 6-2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in se
2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

* * * * *

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Steven T. Miller,
Deputy Commissioner for
Services and Enforcement,
Internal Revenue Service.

Approved *June 10, 2010*.

Michael F. Mundaca,
Assistant Secretary
of the Treasury (Tax Policy).

Signed this *4th* day of *June*, 2010.

Phyllis C. Borzi,
Assistant Secretary
Employee Benefits
Security Administration
Department of Labor

OCIIO-9991-IFC

Approved: *June 8, 2010*.

Jay Angoff,
Director,
Office of Consumer Information
and Insurance Oversight.

Approved: *June 9, 2010*.

Kathleen Sebelius,

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Chapter I

Accordingly, 26 CFR Parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

1. The authority citation for part 54 is amended by adding entries for §§54.9815-1251T and 54.9815-2714T in numerical orde follows:

Authority: 26 U.S.C. 7805. * * *

Section 54.9815-1251T also issued under 26 U.S.C. 9833.

Section 54.9815-2714T also issued under 26 U.S.C. 9833. * * *

2. Section 54.9815-1251T is added to read as follows:

§54.9815-1251T Preservation of right to maintain existing coverage (temporary).

(a) *Definition of grandfathered health plan coverage*—(1) *In general*—(i) *Grandfathered health plan coverage* means coverag health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains th of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan cove one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfather rules of this section apply separately to each benefit package made available under a group health plan or health insurance c

(ii) Subject to the rules of paragraph (f) of this section for collectively bargained plans, if an employer or employee organizatio policy, certificate, or contract of insurance after March 23, 2010 (because, for example, any previous policy, certificate, or con being renewed), then that policy, certificate, or contract of insurance is not a grandfathered health plan with respect to the ind health plan.

(2) *Disclosure of grandfather status*—(i) To maintain status as a grandfathered health plan, a plan or health insurance covera statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or hea that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protectio Act and must provide contact information for questions and complaints.

(ii) The following model language can be used to satisfy this disclosure requirement:

> This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” un Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathere can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathe means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to example, the requirement for the provision of preventive health services without any cost sharing. However, grandfath plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and w a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact info ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor 3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also Department of Health and Human Services at *www.healthreform.gov*.]

(3) *Documentation of plan or policy terms on March 23, 2010*. To maintain status as a grandfathered health plan, a group hea insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered he

(i) Maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and

(ii) Make such records available for examination upon request.

(4) *Family members enrolling after March 23, 2010*. With respect to an individual who is enrolled in a group health plan or hea on March 23, 2010, grandfathered health plan coverage includes coverage of family members of the individual who enroll afte grandfathered health plan coverage of the individual.

(5) *Examples*. The rules of this paragraph (a) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan not maintained pursuant to a collective bargaining agreement provides coverage thr insurance policy from Issuer X on March 23, 2010. For the plan year beginning January 1, 2012, the plan enters into a new po

(ii) *Conclusion*. In this *Example 1*, for the plan year beginning January 1, 2012, the group health insurance coverage issued b grandfathered health plan under the rules of paragraph (a)(1)(ii) of this section because the policy issued by Z did not provide 2010.

Example 2. (i) *Facts*. A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit pa 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan replaces the is new issuer.

(ii) *Conclusion*. In this *Example 2*, the coverage under Option H is not grandfathered health plan coverage as of July 1, 2013, in paragraph (a)(1)(ii) of this section. Whether the coverage under Options F and G is grandfathered health plan coverage is d rules of this section, including paragraph (g) of this section. If the plan enters into a new policy, certificate, or contract of insur Option G's status as a grandfathered health plan would cease under paragraph (a)(1)(ii) of this section.

(b) *Allowance for new employees to join current plan*—(1) *In general*. Subject to paragraph (b)(2) of this section, a group heal insurance coverage provided in connection with the group health plan) that provided coverage on March 23, 2010 and has re grandfathered health plan (consistent with the rules of this section, including paragraph (g) of this section) is grandfathered he new employees (whether newly hired or newly enrolled) and their families enrolling in the plan after March 23, 2010.

(2) *Anti-abuse rules*—(i) *Mergers and acquisitions*. If the principal purpose of a merger, acquisition, or similar business restruc individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

(ii) *Change in plan eligibility*. A group health plan or health insurance coverage (including a benefit package under a group he a grandfathered health plan if —

(A) Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan or health insuranc the employees were covered on March 23, 2010 (the transferor plan);

(B) Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating it were an amendment of the transferor plan would cause a loss of grandfather status under the provisions of paragraph (g)(1

(C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, c cost of coverage is not a bona fide employment-based reason.

(3) *Examples*. The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan offers two benefit packages on March 23, 2010, Options F and G. During a subsequ period, some of the employees enrolled in Option F on March 23, 2010 switch to Option G.

(ii) *Conclusion*. In this *Example 1*, the group health coverage provided under Option G remains a grandfathered health plan u paragraph (b)(1) of this section because employees previously enrolled in Option F are allowed to enroll in Option G as new e

Example 2. (i) *Facts*. Same facts as *Example 1*, except that the plan sponsor eliminates Option F because of its high cost and covered under Option F to Option G. If instead of transferring employees from Option F to Option G, Option F was amended t Option G, then Option F would cease to be a grandfathered health plan.

(ii) *Conclusion*. In this *Example 2*, the plan did not have a bona fide employment-based reason to transfer employees from Op Therefore, Option G ceases to be a grandfathered health plan with respect to all employees. (However, any other benefit pac plan sponsor is analyzed separately under the rules of this section.)

Example 3. (i) *Facts*. A group health plan offers two benefit packages on March 23, 2010, Options H and I. On March 23, 201 coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the close another plant. The employer eliminates Option H and the employees that are moved are transferred to Option I. If instead of t from Option H to Option I, Option H was amended to match the terms of Option I, then Option H would cease to be a grandfa

(ii) *Conclusion*. In this *Example 3*, the plan has a bona fide employment-based reason to transfer employees from Option H to Option I does not cease to be a grandfathered health plan.

(c) *General grandfathering rule*—(1) Except as provided in paragraphs (d) and (e) of this section, subtitles A and C of title I of and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into sect section 715) do not apply to grandfathered health plan coverage. Accordingly, the provisions of PHS Act sections 2701, 2702 2707, 2709 (relating to coverage for individuals participating in approved clinical trials, as added by section 10103 of the Patie Affordable Care Act), 2713, 2715A, 2716, 2717, 2719, and 2719A, as added or amended by the Patient Protection and Afford apply to grandfathered health plans. (In addition, *see* 45 CFR 147.140(c), which provides that the provisions of PHS Act secti section 2711 insofar as it relates to annual limits, do not apply to grandfathered health plans that are individual health insuran

(2) To the extent not inconsistent with the rules applicable to a grandfathered health plan, a grandfathered health plan must c requirements of the Code, the PHS Act, and ERISA applicable prior to the changes enacted by the Patient Protection and Aff

(d) *Provisions applicable to all grandfathered health plans*. The provisions of PHS Act section 2711 insofar as it relates to lifet provisions of PHS Act sections 2712, 2714, 2715, and 2718, apply to grandfathered health plans for plan years beginning on 2010. The provisions of PHS Act section 2708 apply to grandfathered health plans for plan years beginning on or after Janua

(e) *Applicability of PHS Act sections 2704, 2711, and 2714 to grandfathered group health plans and group health insurance c* provisions of PHS Act section 2704 as it applies with respect to enrollees who are under 19 years of age, and the provisions insofar as it relates to annual limits, apply to grandfathered health plans that are group health plans (including group health in plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2704 apply generally to grandfather group health plans (including group health insurance coverage) for plan years beginning on or after January 1, 2014.

(2) For plan years beginning before January 1, 2014, the provisions of PHS Act section 2714 apply in the case of an adult chi grandfathered health plan that is a group health plan only if the adult child is not eligible to enroll in an eligible employer-spon defined in section 5000A(f)(2)) other than a grandfathered health plan of a parent. For plan years beginning on or after Janua provisions of PHS Act section 2714 apply with respect to a grandfathered health plan that is a group health plan without regar child is eligible to enroll in any other coverage.

(f) *Effect on collectively bargained plans*—(1) *In general*. In the case of health insurance coverage maintained pursuant to on bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 20 grandfathered health plan coverage at least until the date on which the last of the collective bargaining agreements relating to in effect on March 23, 2010 terminates. Any coverage amendment made pursuant to a collective bargaining agreement relati amends the coverage solely to conform to any requirement added by subtitles A and C of title I of the Patient Protection and A the amendments made by those subtitles, and the incorporation of those amendments into section 9815 and ERISA section 7 termination of the collective bargaining agreement. After the date on which the last of the collective bargaining agreements re that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuar bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the coverage that were in effect on March 23, 2010) and, for any changes in insurance coverage after the termination of the colle agreement, under the rules of paragraph (a)(1)(ii) of this section.

(2) *Examples*. The rules of this paragraph (f) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan maintained pursuant to a collective bargaining agreement provides coverage throug insurance policy from Issuer W on March 23, 2010. The collective bargaining agreement has not been amended and will not 31, 2011. The group health plan enters into a new group health insurance policy with Issuer Y for the plan year starting on Ja

(ii) *Conclusion*. In this *Example 1*, the group health plan, and the group health insurance policy provided by Y, remains a gran with respect to existing employees and new employees and their families because the coverage is maintained pursuant to a

agreement ratified prior to March 23, 2010 that has not terminated.

Example 2. (i) *Facts*. Same facts as *Example 1*, except the coverage with Y is renewed under a new collective bargaining agr January 1, 2012, with the only changes since March 23, 2010 being changes that do not cause the plan to cease to be a gran under the rules of this section, including paragraph (g) of this section.

(ii) *Conclusion*. In this *Example 2*, the group health plan remains a grandfathered health plan pursuant to the rules of this sect group health insurance policy provided by Y remains a grandfathered health plan under the rules of this section, including par section.

(g) *Maintenance of grandfather status*—(1) *Changes causing cessation of grandfather status*. Subject to paragraph (g)(2) of t this paragraph (g)(1) describe situations in which a group health plan or health insurance coverage ceases to be a grandfathe

(i) *Elimination of benefits*. The elimination of all or substantially all benefits to diagnose or treat a particular condition causes a health insurance coverage to cease to be a grandfathered health plan. For this purpose, the elimination of benefits for any ne diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular co

(ii) *Increase in percentage cost-sharing requirement*. Any increase, measured from March 23, 2010, in a percentage cost-sha as an individual's coinsurance requirement) causes a group health plan or health insurance coverage to cease to be a grandf

(iii) *Increase in a fixed-amount cost-sharing requirement other than a copayment.* Any increase in a fixed-amount cost-sharing a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a gro insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requireme March 23, 2010 exceeds the maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section).

(iv) *Increase in a fixed-amount copayment*. Any increase in a fixed-amount copayment, determined as of the effective date of group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total increase in the copaym March 23, 2010 exceeds the greater of:

(A) An amount equal to $5 increased by medical inflation, as defined in paragraph (g)(3)(i) of this section (that is, $5 times me or

(B) The maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section), determined by expressing the total i copayment as a percentage.

(v) *Decrease in contribution rate by employers and employee organizations*—(A) *Contribution rate based on cost of coverage* group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreas based on cost of coverage (as defined in paragraph (g)(3)(iii)(A) of this section) towards the cost of any tier of coverage for ar situated individuals (as described in §54.9802-1(d)) by more than 5 percentage points below the contribution rate for the cove includes March 23, 2010.

(B) *Contribution rate based on a formula*. A group health plan or group health insurance coverage ceases to be a grandfather employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(3)(iii)(B) c the cost of any tier of coverage for any class of similarly situated individuals (as described in §54.9802-1(d)) by more than 5 p contribution rate for the coverage period that includes March 23, 2010.

(vi) *Changes in annual limits*—(A) *Addition of an annual limit*. A group health plan, or group health insurance coverage, that, c not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the coverage imposes an overall annual limit on the dollar value of benefits.

(B) *Decrease in limit for a plan or coverage with only a lifetime limit*. A group health plan, or group health insurance coverage, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all be grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lowe the lifetime limit on March 23, 2010.

(C) *Decrease in limit for a plan or coverage with an annual limit*. A group health plan, or group health insurance coverage, tha imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or healt decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an c March 23, 2010 on the dollar value of all benefits).

(2) *Transitional rules*—(i) *Changes made prior to March 23, 2010*. If a group health plan or health insurance issuer makes the the terms of the plan or health insurance coverage, the changes are considered part of the terms of the plan or health insurar 23, 2010 even though they were not effective at that time and such changes do not cause a plan or health insurance coverag grandfathered health plan:

(A) Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010;

(B) Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance departme

(C) Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March

(ii) *Changes made after March 23, 2010 and adopted prior to issuance of regulations*. If, after March 23, 2010, a group health insurance issuer makes changes to the terms of the plan or health insurance coverage and the changes are adopted prior to changes will not cause the plan or health insurance coverage to cease to be a grandfathered health plan if the changes are re effective as of the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 201 plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to cease to be a grandfath the rules of this section, including paragraph (g)(1) of this section. For this purpose, changes will be considered to have been 14, 2010 if:

(A) The changes are effective before that date;

(B) The changes are effective on or after that date pursuant to a legally binding contract entered into before that date;

(C) The changes are effective on or after that date pursuant to a filing before that date with a State insurance department; or

(D) The changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that da

(3) *Definitions*—(i) *Medical inflation defined*. For purposes of this paragraph (g), the term *medical inflation* means the increase the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by Labor using the 1982 — 1984 base of 100. For this purpose, the increase in the overall medical care component is computed (the overall medical care component of the CPI-U (unadjusted) published by the Department of Labor for March 2010, using t of 100) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that a

(ii) *Maximum percentage increase defined*. For purposes of this paragraph (g), the term *maximum percentage increase* mean defined in paragraph (g)(3)(i) of this section), expressed as a percentage, plus 15 percentage points.

(iii) *Contribution rate defined*. For purposes of paragraph (g)(1)(v) of this section:

(A) *Contribution rate based on cost of coverage*. The term *contribution rate based on cost of coverage* means the amount of c an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The total cost of c in the same manner as the applicable premium is calculated under the COBRA continuation provisions of section 4980B(f)(4) and section 2204 of the PHS Act. In the case of a self-insured plan, contributions by an employer or employee organization a of coverage minus the employee contributions towards the total cost of coverage.

(B) *Contribution rate based on a formula*. The term *contribution rate based on a formula* means, for plans that, on March 23, 2 contributions based on a formula (such as hours worked or tons of coal mined), the formula.

(4) *Examples*. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. (i) *Facts*. On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20% for inpatient su subsequently amended to increase the coinsurance requirement to 25%.

(ii) *Conclusion*. In this *Example 1*, the increase in the coinsurance requirement from 20% to 25% causes the plan to cease to health plan.

Example 2. (i) *Facts*. Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health c for which is a combination of counseling and prescription drugs. Subsequently, the plan eliminates benefits for counseling.

(ii) *Conclusion*. In this *Example 2*, the plan ceases to be a grandfathered health plan because counseling is an element that is condition. Thus the plan is considered to have eliminated substantially all benefits for the treatment of the condition.

Example 3. (i) *Facts*. On March 23, 2010, a grandfathered health plan has a copayment requirement of $30 per office visit for subsequently amended to increase the copayment requirement to $40. Within the 12-month period before the $40 copaymen greatest value of the overall medical care component of the CPI-U (unadjusted) is 475.

(ii) *Conclusion*. In this *Example 3*, the increase in the copayment from $30 to $40, expressed as a percentage, is 33.33% (40 0.3333; 0.3333 = 33.33%). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.2269 (475 87.858 ÷ 387.142 = 0.2269). The maximum percentage increase permitted is 37.69% (0.2269 = 22.69%; 22.69% + 15% = 37 does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a gra

Example 4. (i) *Facts*. Same facts as *Example 3*, except the grandfathered health plan subsequently increases the $40 copayr for a later plan year. Within the 12-month period before the $45 copayment takes effect, the greatest value of the overall med the CPI-U (unadjusted) is 485.

(ii) *Conclusion*. In this *Example 4*, the increase in the copayment from $30 (the copayment that was in effect on March 23, 20 as a percentage, is 50% (45 - 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Medical inflation (as defined in paragraph (g)(3)(i) of this se is 0.2527 (485 - 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527). The increase that would cause a plan to cease to be a grand under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25 or $6.26 ($5 x 0.2527 = $1.26; $1.26 + $5 = $6.26).

Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment requirement at that time causes the pla grandfathered health plan.

Example 5. (i) *Facts*. On March 23, 2010, a grandfathered health plan has a copayment of $10 per office visit for primary care subsequently amended to increase the copayment requirement to $15. Within the 12-month period before the $15 copaymen greatest value of the overall medical care component of the CPI-U (unadjusted) is 415.

(ii) *Conclusion*. In this *Example 5*, the increase in the copayment, expressed as a percentage, is 50% (15 - 10 = 5; 5 ÷ 10 = 0 inflation (as defined in paragraph (g)(3) of this section) from March 2010 is 0.0720 (415.0 - 387.142 = 27.858; 27.858 ÷ 387.1 increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the g percentage increase of 22.20% (0.0720 = 7.20%; 7.20% + 15% = 22.20), or $5.36 ($5 x 0.0720 = $0.36; $0.36 + $5 = $5.36). copayment in this *Example 5* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(would permit an increase in the copayment of up to $5.36.

Example 6. (i) *Facts*. The same facts as *Example 5*, except on March 23, 2010, the grandfathered health plan has no copaym for primary care providers. The plan is subsequently amended to increase the copayment requirement to $5.

(ii) *Conclusion*. In this *Example 6*, medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.072 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under of this section is $5.36 ($5 x 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 6* is less tha pursuant to paragraph (g)(1)(iv)(A) of this section of $5.36. Thus, the $5 increase in copayment does not cause the plan to ce grandfathered health plan.

Example 7. (i) *Facts*. On March 23, 2010, a self-insured group health plan provides two tiers of coverage — self-only and fam contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

(ii) *Conclusion*. In this *Example 7*, the decrease of 10 percentage points for family coverage in the contribution rate based on the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the sam result.

Example 8. (i) *Facts*. On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan y only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1000 for self-only co family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5000 - 1000)/5000) for self-only cov - 4000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6000 for self-only coverage and $1 coverage. The employee contributions for that plan year are $1200 for self-only coverage and $5000 for family coverage. Thu based on cost of coverage is 80% ((6000 - 1200)/6000) for self-only coverage and 67% ((15,000 - 5000)/15,000) for family co

(ii) *Conclusion*. In this *Example 8*, because there is no change in the contribution rate based on cost of coverage, the plan ret grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through section 125 of the Internal Revenue Code.

Example 9. (i) *Facts*. Before March 23, 2010, Employer W and Individual B enter into a legally binding employment contract tl health coverage upon termination. Prior to termination, B is covered by W's self-insured grandfathered group health plan. B is 23, 2010 and W purchases a new health insurance policy providing coverage to B, consistent with the terms of the employme

(ii) *Conclusion*. In this *Example 9*, because no individual is enrolled in the health insurance policy on March 23, 2010, it is not plan.

(h) *Expiration date*. This section expires on or before June 14, 2013.

3. Section 54.9815-2714T is amended by revising paragraphs (h) and (i) to read as follows:

* * * * *

(h) *Applicability date*. The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* §54.9 determining the application of this section to grandfathered health plans.

(i) *Expiration date*. This section expires on or before May 10, 2013.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

4. The authority citation for part 602 continues to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

5. Section 602.101(b) is amended by adding the following entry in numerical order to the table to read as follows:

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
54.9815-1251T	1545-2178
* * * * *	

Note

(Filed by the Office of the Federal Register on June 14, 2010, 11:15 a.m., and published in the issue of the Federal Register f F.R. 34537)

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[1] The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is dis "health plan", as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insu

[2] Excepted benefits generally include dental-only and vision-only plans, most health flexible spending arrangements, Mediga accidental death and dismemberment coverage. For more information on excepted benefits, see 26 CFR 54.9831-1, 29 CFR 146.145, and 45 CFR 148.220.

[3] *See* 64 FR 70164 (December 15, 1999).

[4] Code section 9815 incorporates the preemption provisions of PHS Act section 2724. Prior to the Affordable Care Act, there preemption provisions in chapter 100 of the Code.

[5] Similarly situated individuals are described in the HIPAA nondiscrimination regulations at 26 CFR 54.9802-1(d), 29 CFR 25 146.121(d).

[6] Independent of these rules regarding the impact on grandfather status of newly adopted or reduced annual limits, group he individual health insurance coverage (other than individual health insurance policies that are grandfathered health plans) are PHS Act section 2711, which permits restricted annual limits (as defined in regulations) until 2014. The Departments expect t regarding restricted annual limits in the very near future.

[7] The Affordable Care Act adds section 715(a)(1) to ERISA and section 9815(a)(1) to the Code to incorporate the provisions the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providi coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 throu sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2 sections of prior law renumbered, with some, mostly minor, changes. Section 1251 of the Affordable Care Act, as modified by Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the date grandfathered health plans) are only subject to certain provisions.

[8] For individuals who have coverage through an insured group health plans subject to a collective bargaining agreement ratif 2010, an individual's coverage is grandfathered at least until the date on which the last agreement relating to the coverage th March 23, 2010, terminates. These collectively bargained plans may make any permissible changes to the benefit structure b terminates and remain grandfathered. After the termination date, grandfather status will be determined by comparing the plan 23, 2010 to the changes that the plan made before termination under the rules established by these interim final regulations.

[9] Medical inflation is defined in these interim regulations by reference to the overall medical care component of the CPI.

[10] Available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*.

[11] http://www.nber.org/reporter/summer06/buchmueller.html "Consumer Demand for Health Insurance" The National Bureau (Buchmueller, 2006)

[12] *http://content.healthaffairs.org/cgi/reprint/19/3/158.pdf* "Health Plan Switching: Choice Or Circumstance?" (Cunnigham and

[13] http://www.kaiserhealthnews.org/Stories/2009/December/01/Medicare-Drug-Plan.aspx "Seniors Often Reluctant To Switch Plans" (2009, Kaiser Health News/Washington Post).

[14] *http://www.ncbi.nlm.nih.gov/pubmed/16704882* "The effect of quality information on consumer health plan switching: evide Health Care Action Group." (Abraham, Feldman, Carlin, and Christianson, 2006)

[15] Erika C. Ziller, Andrew F. Coburn, Timothy D. McBride, and Courtney Andrews. Patterns of Individual Health Insurance Co *Health Affairs* Nov/Dec 2004: 210-221.

[16] Melinda Beeuwkes Bustin, M. Susan Marquis, and Jill M. Yegian. The Role of the Individual Health Insurance Market and *Health Affairs* 2004; 23(6): 79-90.

[17] Kaiser Family Foundation State Health Facts (2010), *http://www.statehealthfacts.org/comparetable.jsp?ind=351&cat=7*.

[18] All participant counts and the estimates of individual policies are from the 2009 Current Population Survey (CPS).

[19] Estimate is from the 2007 Census of Government.

[20] Under the Affordable Care Act and these interim final regulations, if a plan that is not a collectively bargained plan change 23, 2010, it is no longer a grandfathered health plan.

[21] The analysis is limited to firms that responded to the Kaiser/HRET survey in both 2008 and 2009. Large firms are overrepr sample. New firms and firms that went out of business in 2008 or 2009 are underrepresented. The Departments present resu firms and small firms, and weight the results to the number of employees in each firm-size category. Results are presented fo Kaiser/HRET survey gathers information about the PPO with the most enrollment in each year. If enrollment at a given emplo PPO to a different PPO between 2008 and 2009, then the PPO with the most enrollment in 2009 may be different than the PP enrollment in 2008. To the extent this occurred, the estimates presented here may overestimate the fraction of plans that will status. However, given the behavioral assumptions of the analysis and the need to present a range of results, the Departmen overestimation will not have a noticeable effect on estimates presented here.

[22] The regulation allows plans to increase fixed-amount copayments by an amount that does not exceed $5 increased by me analysis, the Departments used a threshold of $5, rather than the threshold of approximately $5.20 that would be allowed by regulations. There would have been no difference in the results if the Departments had used $5.20 rather than $5 as the thres

[23] In contrast, for self-insured plans, a change in third party administrator in and of itself does not cause a group health plan grandfathered health plan, provided changes do not exceed the limits of paragraph (g)(1) of these interim final regulations.

[24] Some employers made changes which exceeded at least one cost-sharing threshold and decreased the employer's share than five percent.

[25] Employers who offer plans on a calendar year basis generally make decisions about health plan offerings during the prece decisions for calendar 2009 were generally made during the summer of 2008. At that time, the depth of the coming recession most observers.

[26] Among the 76 percent of small employers and 84 percent of large employers who could have accommodated the cost-sha desired to make within the parameters of these interim final regulations, 13 percent of the small employers and three percent changed issuers.

[27] Adele M. Kirk. The Individual Insurance Market: A Building Block for Health Care Reform? *Health Care Financing Organiz Synthesis*. May 2008.

[28] Ibid.

[29] *http://content.healthaffairs.org/cgi/content/full/23/6/210#R14* "Patterns of Individual Health Insurance Coverage" *Health Af*

[30] *http://content.healthaffairs.org/cgi/content/full/hlthaff.25.w226v1/DC1* "Consumer Decision Making in the Individual Health *Health Affairs* (Marquis et al, 2006).

[31] The Departments' estimate of the number of ERISA-covered health plans was obtained from the 2008 Medical Expenditur Insurance component. The estimate of the number of policy holders was obtained from the 2009 Current Population Survey. to estimate the percentage of plans that will retain their grandfathered plans was discussed above.

[32] EBSA estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employm Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

[33] The Department's estimate of the number of state and local governmental health plans was obtained from the 2007 Censu estimate of the number of policy holders in the individual market were obtained from the 2009 Current Population Survey. The estimate the percentage of state and local governmental plans and individual market policies that will retain their grandfathere was discussed above.

[34] EBSA estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employm Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

[35] The Department is not certain on the number of products offered in the individual market and requests comments. After re products offered by various insurers in the individual market the Department used an estimate of 15 which it believes is a high

Prev Up Next
Home

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