Internal Revenue
bulletin

Bulletin No. 2010-29
July 19, 2010

HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

SPECIAL ANNOUNCEMENT

Notice 2010–51, page 83.
This notice invites public comments regarding guidance to be provided to payors and other affected persons concerning the new requirements under the amendments to section 6041 of the Code expanding reporting to payments to corporations and to payments of gross proceeds and with respect to property.

EMPLOYEE PLANS

T.D. 9489, page 55.
REG–118412–10, page 85.
Temporary and proposed regulations under section 9815 of the Code provide guidance concerning the rules for group health plans and health insurance coverage relating to status as a grandfathered health plan under the Affordable Care Act.

EXEMPT ORGANIZATIONS

Announcement 2010–45, page 87.
The IRS has revoked its determination that Baby Boomers and Beyond, Inc., of Denham Springs, LA; Children's Angelcare Aid International, Inc., of San Diego, CA; Institute for Unpopular Culture of San Francisco, CA; Jolene's Horse Rescue of Palmdale, CA; Military Order of the Cootie of the US Tent # 20 of Wellston, OK; Rochester Hills Dance & Arts Society of Rochester Hills, MI; City Club of Dallas, TX; Four a Foundation an Integrated Auxiliary of First Baptist Church of Garland, TX; Georgian Community Services Program, Inc., of Morrow, GA; TARU Gardens, Inc., of Charlottesville, VA; and UTAH Citizens Alliance of Salt Lake City, UT, qualify as organizations in sections 501(c)(3) and 170(c)(2) of the Code.

EXCISE TAX

T.D. 9489, page 55.
REG–118412–10, page 85.
Temporary and proposed regulations under section 9815 of the Code provide guidance concerning the rules for group health plans and health insurance coverage relating to status as a grandfathered health plan under the Affordable Care Act.

ADMINISTRATIVE

Notice 2010–51, page 83.
This notice invites public comments regarding guidance to be provided to payors and other affected persons concerning the new requirements under the amendments to section 6041 of the Code expanding reporting to payments to corporations and to payments of gross proceeds and with respect to property.

Announcement of Declaratory Judgment Proceedings Under Section 7428 begins on page 87.
Finding Lists begin on page ii.

Department of the Treasury
Internal Revenue Service

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents are compiled semiannually into Cumulative Bulletins, which are sold on a single-copy basis.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.
This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.
This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.
To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.
This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

Section 9815.—Additional Market Reforms

T.D. 9489

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

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

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer 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 in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding status as a grandfathered health plan.

DATES: *Effective Date:* These interim final regulations are effective on June 14, 2010, except that the amendments to 26 CFR 54.9815–2714T, 29 CFR 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 Department will be shared with 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 name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments 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 Administration, Room N–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.dol.gov/ebsa*, and available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code OCIIO–9991–IFC. Because of staff and resource limitations, the 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 instructions under the "More 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 comment period to either of 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 government identification, commenters are encouraged to leave their comments in the OCIIO drop slots located in the main lobby of the building. A stamp-in clock is available 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 arrival with one of our staff members.

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the 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 the public, including any personally identifiable or confidential business information that is included in a comment. The Departments post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the 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 three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 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 comments, phone 1–800–743–3951.

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, Washington, DC 20044.
- *Hand or courier delivery*: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–118412–10), Courier's 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, Washington, DC from 9 a.m. 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, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Jim Mayhew, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (410) 786–1565.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor's website (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (*http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp*) and information on health reform can be found at *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; the Health Care and Education Reconciliation Act (the Reconciliation Act), Pub. L. 111–152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions in part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes. Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the date of enactment (that is, grandfathered health plans) are only subject 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 of ERISA conflicts with part A of title XXVII of the PHS Act with respect to group health plans or group health insurance coverage, the PHS Act provisions apply. Similarly, the Affordable Care Act adds section 9815(a)(2) of the Code, which provides that, to the extent that any provi-

[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 distinct from the term "health plan", as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

sion of subchapter B of chapter 100 of the Code conflicts with part A of title XXVII of the PHS Act with respect to group health plans or group health insurance coverage, the PHS Act provisions apply. Therefore, although ERISA section 715(a)(1) and Code section 9815(a)(1) incorporate by reference new provisions, they do not affect preexisting sections of ERISA or the Code unless they cannot be read consistently with an incorporated provision of the PHS Act. For example, ERISA section 732(a) generally provides that part 7 of ERISA — and Code section 9831(a) generally provides that chapter 100 of the Code — does not apply to plans with less than two participants who are current employees (including retiree-only plans that cover less than two participants who are current employees). Prior to enactment of the Affordable Care Act, the PHS Act had a parallel provision at section 2721(a). After the Affordable Care Act amended, reorganized, and renumbered most of title XXVII of the PHS Act, that exception no longer exists. Similarly, ERISA section 732(b) and (c) generally provides that the requirements of part 7 of ERISA — and Code section 9831(b) and (c) generally provides that the requirements of chapter 100 of the Code — do not apply to excepted benefits.[2] Prior to enactment of the Affordable Care Act, the PHS Act had a parallel section 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 to excepted benefits. After the Affordable Care Act amended and renumbered PHS Act section 2721(c) and (d) as section 2722(b) and (c), that exception could be read to 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 excepted benefits to 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 requirements of ERISA and the Code. Accordingly, the exceptions of ERISA section 732 and Code section 9831 for very small plans and certain retiree-only health plans, and for excepted benefits, remain in effect and, thus, ERISA section 715 and Code section 9815, as added by the Affordable Care Act, do not apply to such plans or excepted benefits.

Moreover, there is no express indication in the legislative history of an intent to treat issuers of group health insurance coverage or nonfederal governmental plans (that are subject to the PHS Act) any differently in this respect from plans subject to ERISA and the Code. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) operate under a Memorandum of Understanding (MOU)[3] that implements section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996, and subsequent amendments, and provides that requirements over which two or more Secretaries have responsibility ("shared provisions") must be administered so as to have the same effect at all times. HIPAA section 104 also requires the coordination of policies relating to enforcing the shared provisions in order to avoid 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 private sector plans or that excepted benefits offered by nonfederal governmental plans should be treated differently from excepted benefits offered by private sector plans. Because treating nonfederal governmental retiree-only plans and excepted benefits provided by nonfederal governmental plans differently would create confusion with respect to the obligations of issuers that do not distinguish whether a group health plan is subject to ERISA or the PHS Act, and in light of the MOU, the Department of Health and Human Services (HHS) does not intend to use its resources to enforce the requirements of HIPAA or the Affordable Care Act with respect to nonfederal governmental retiree-only plans or with respect to excepted benefits provided by nonfederal 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 individual market provisions over group and individual health insurance issuers. HHS enforces these provisions with respect to issuers only if it determines that the State has "failed to substantially enforce" one of the Federal provisions. Furthermore, the PHS Act preemption provisions allow States to impose requirements on issuers in the group and individual markets that are more protective than the Federal provisions. However, HHS is encouraging States not to apply the provisions of title XXVII of the PHS Act to issuers of retiree-only plans or of excepted benefits. HHS advises States that if they 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 substantially enforce 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 are incorporated into ERISA section 715). The preemption provisions of ERISA section 731 and PHS Act section 2724[4] (implemented in 29 CFR 2590.731(a) and 45 CFR 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 Act, are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of the Affordable Care Act. Accordingly, State laws that impose on health insurance issuers requirements that are stricter than the requirements imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

[2] Excepted benefits generally include dental-only and vision-only plans, most health flexible spending arrangements, Medigap policies, and accidental death and dismemberment coverage. For more information on excepted benefits, see 26 CFR 54.9831–1, 29 CFR 2590.732, 45 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 were no express preemption provisions in chapter 100 of the Code.

The Departments are issuing regulations implementing the revised PHS Act sections 2701 through 2719A in several phases. The first publication in this series was a Request for Information relating to the medical loss ratio provisions of PHS Act section 2718, published in the **Federal Register** on April 14, 2010 (75 FR 19297). The second publication was interim final regulations implementing PHS Act section 2714 (requiring dependent 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 27122]). This document contains interim final regulations implementing section 1251 of the Affordable Care Act (relating to grandfathered health plans), as well as adding a cross-reference to these interim final regulations in the regulations implementing PHS Act section 2714. The implementation of other provisions in 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 Existing Coverage (26 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 Reconciliation Act, provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (the date of enactment of the Affordable Care Act), are subject only to certain provisions of the Affordable Care Act. The statute and these interim final regulations refer to these plans and health 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 the goals of ensuring access to affordable essential coverage and improving the quality of coverage. Section 1251 provides that nothing in the Affordable Care Act requires an individual to terminate the coverage in which the individual was enrolled on March 23, 2010. It also generally provides that, with respect to group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, various requirements of the Act shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after March 23, 2010. However, to ensure access to coverage with certain particularly significant protections, Congress required grandfathered health plans to comply with a subset of the Affordable Care Act's health reform provisions. Thus, for example, grandfathered health plans must comply with the prohibition on rescissions of coverage except in the case of fraud or intentional misrepresentation and the elimination of lifetime limits (both of which apply for plan years, or in the individual market, policy years, beginning on or after September 23, 2010). On the other hand, grandfathered health plans are not required to comply with certain other requirements of the Affordable Care Act; for example, the requirement that preventive health services be covered without any cost sharing (which otherwise becomes generally applicable for plan years, or in the individual market, policy years, beginning on or after September 23, 2010).

A number of additional reforms apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014. As with the requirements effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, grandfathered health plans 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 requirements that apply to grandfathered health plans.

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

These interim final regulations are designed to ease the transition of the health-care industry into the reforms established by the Affordable Care Act by allowing for gradual implementation of reforms through a reasonable grandfathering rule. A more detailed description of the basis for these interim 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 2590.715–1251, and 45 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 grandfathered health plan with respect to individuals enrolled on March 23, 2010. Paragraph (a)(1) of 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140 of these interim final regulations provides that a group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). The determination under the rules of these interim final regulations is made separately with respect to each benefit package made 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 2590.715–1251, and 45 CFR 147.140 for collectively bargained plans, if an employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010 (because, for example, any previous policy, certificate, or contract of insurance is not being renewed), then that policy, certificate, or contract of insurance is not a grandfathered health plan with respect to the individuals in the group health plan. Any policies sold in the group and individual health insurance markets to new entities or individuals after March 23, 2010 will not be grandfathered

health plans even if the 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 plan materials provided to participants or beneficiaries (in the individual market, primary subscribers) describing the benefits provided under the plan or health insurance coverage, that the plan or health insurance coverage believes that it is a grandfathered health plan within the meaning of section 1251 of the 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. Comments are invited on possible improvements to the model language of grandfathered health plan status. Some have suggested, for example, that each grandfathered health plan be required to list and describe the various consumer protections that do not apply to the plan or health insurance coverage because it is grandfathered, together with their effective dates. The Departments intend to consider any comments regarding possible improvements to the model language in the near term; any changes to the model language that may result from such comments could be published in additional administrative 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 maintain records documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. Such documents could include intervening and current plan documents, health insurance policies, certificates or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates. In addition, the plan or issuer must make such records available for examination. Accordingly, a participant, beneficiary, individual policy subscriber, or State or Federal agency official would be able to inspect such documents to verify the status of the plan or health insurance coverage as a grandfathered health plan. The plan or issuer must maintain such records and make them available for examination 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 health plan as of March 23, 2010 enroll in the plan after March 23, 2010, the plan or health insurance coverage is also a grandfathered health plan with respect to the family members.

C. *Adding New Employees in Paragraph (b) of 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140 of these Interim 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 health plan that provided coverage on March 23, 2010 generally is also a grandfathered health plan with respect to new employees (whether newly hired or newly enrolled) and their families who enroll in the grandfathered health plan after March 23, 2010. These interim final regulations clarify that in such cases, any health insurance coverage provided under the group health plan in which an individual was enrolled on March 23, 2010 is also a grandfathered health plan. To prevent abuse, these interim final regulations provide that if the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan. The goal of this rule is to prevent grandfather status from being bought and sold as a commodity in commercial transactions. These interim final regulations also contain a second anti-abuse rule designed to prevent a plan or issuer from circumventing the limits on changes that cause a plan or health insurance coverage to cease to be a grandfathered health plan under paragraph (g) (described more fully in section II.F of this preamble). This rule in paragraph (b)(2)(ii) addresses a situation under which employees who previously were covered by a grandfathered health plan are transferred to another grandfathered health plan. This rule is intended to prevent efforts to retain grandfather status by indirectly making changes that would result in loss of that status if 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 (e) of 26 CFR 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 specifically provided by the statute and these interim final regulations. The statute and these interim final regulations provide that some provisions of subtitles A and C of title I of the Affordable Care Act continue to apply to all grandfathered health plans and some provisions continue to apply only to grandfathered health plans that are group health plans. These interim final regulations clarify that a grandfathered health plan must continue to comply with the requirements of the PHS Act, ERISA, and the Code that were applicable prior to the changes enacted by the Affordable Care Act, except to the extent supplanted by changes made by the Affordable Care Act. Therefore, the HIPAA portability and nondiscrimination requirements and the Genetic Information Nondiscrimination Act requirements applicable prior to the effective date of the Affordable Care Act continue to apply to grandfathered health plans. In addition, the mental health parity provisions, the Newborns' and Mothers' Health Protection Act provisions, the Women's Health and Cancer Rights Act, and Michelle's Law continue to apply to grandfathered health plans. The following table lists the new health coverage reforms in part A of title 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 Grandfathered Health Plans*	
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 insurance coverage. 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 grandfathered group health plans and group health insurance coverage; not applicable to grandfathered individual health insurance coverage.
§2712 Prohibition on rescissions	Applicable
§2714 Extension of dependent coverage until age 26	Applicable[5]
§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.

E. *Health Insurance Coverage Maintained Pursuant to a Collective Bargaining Agreement of Paragraph (f) of 26 CFR 54.9815–1251T, 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 provide that in the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, the coverage is a grandfathered health plan at least until the date on which the last agreement relating to the coverage that was in effect on March 23, 2010 terminates. Thus, before the last of the applicable collective bargaining agreement terminates, any health insurance coverage provided pursuant to the collective bargaining agreements is a grandfathered health plan, even if there is a change in issuers (or any other change described 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) during the period of the agreement. The statutory language of the provision refers solely to "health insurance coverage" and does not refer to a group health plan; therefore, these interim final regulations apply this provision only to insured plans maintained pursuant to a collective bargaining agreement and not to self-insured plans. After the date on which the last of the collective bargaining agreements terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of paragraph (g). This determination is made by comparing the terms of the coverage on the date of determination with the terms of the coverage that were in effect on March 23, 2010. A change in issuers during the period of the agreement, by itself, would not cause the plan to cease to be a grandfathered health plan at the termination of the agreement. However, for a change in issuers after the termination of the agreement, the rules of paragraph (a)(1)(ii) of 26 CFR 54.9815–1251T, 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 collectively bargained plans with respect to the Affordable Care Act requirements. Questions have arisen as to whether section 1251(d) as enacted in the Affordable Care Act similarly operated to delay the application of the Affordable Care Act's requirements to collectively bargained plans — specifically, whether the provision of section 1251(d) that exempts collectively bargained plans from requirements for the duration of the agreement effectively provides the plans with a delayed effective date with respect to all new PHS Act requirements (in contrast to the rules for grandfathered health plans which provide that specified PHS Act provisions apply to all plans, including grandfathered health plans). However, the statutory language that applies only to collectively bargained plans, as signed into law as part of the Affordable Care Act, provides that insured collectively bargained plans in which individuals were enrolled on the date of enactment are included in the

[5] For a group health plan or group health insurance coverage that is a grandfathered health plan for plan years beginning before January 1, 2014, PHS Act section 2714 is applicable in the case of an adult child only if the adult child is not eligible for other employer-sponsored health plan coverage. The interim final regulations relating to PHS Act section 2714, published in 75 FR 27122 (May 13, 2010), and these interim final regulations clarify that, in the case of an adult child who is eligible for coverage under the employer-sponsored plans of both parents, neither parent's 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 employer-sponsored plan.

definition of a grandfathered health plan. Therefore, collectively bargained plans (both insured and self-insured) that are grandfathered health plans are subject to the same requirements as other grandfathered health plans, and are not provided with a delayed effective date for PHS Act provisions with which other grandfathered health plans must comply. Thus, the provisions that apply to grandfathered health plans apply to collectively bargained plans before and after termination of the last of the applicable collective bargaining agreement.

F. *Maintenance of Grandfather Status of Paragraph (g) of 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140 of 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 have the plan or coverage considered the same as that in existence on March 23, 2010, so as to maintain status as a grandfathered health plan. Some have suggested that any change would cause a plan or health insurance coverage to be considered different and thus cease to be a grandfathered health plan. Others have suggested that any degree of change, no matter how large, is irrelevant provided the plan or health insurance coverage can trace some continuous 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, coordinated rules are set forth for determining when changes to the terms of a plan or health insurance coverage cause the plan or coverage to cease to be a grandfathered health plan. The first of those rules (in paragraph (g)(1)(i)) constrains the extent to which the scope of benefits can be reduced. It provides that the elimination of all or substantially all benefits to diagnose or treat a particular condition causes a plan or health insurance coverage to cease to be a grandfathered health plan. If, for example, a plan eliminates all benefits for cystic fibrosis, the plan ceases to be a grandfathered health plan (even though this condition may affect relatively few individuals covered under the plan). Moreover, for purposes of paragraph (g)(1)(i), the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition. An example in these interim final regulations illustrates that if a plan provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, 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 fixed-amount and the percentage cost-sharing requirements that are imposed with respect to individuals for covered items and services. Plans and issuers can choose to make larger increases to fixed-amount or percentage cost-sharing requirements than permissible under these interim final regulations, but at that point the individual's plan or health insurance coverage would cease to be grandfathered health plan coverage. A more detailed description of the 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. Coinsurance automatically rises with medical inflation. Therefore, changes to the *level* of coinsurance (such as moving from a requirement that the patient pay 20 percent to a requirement that the patient pay 30 percent of inpatient surgery costs) would significantly alter the level of benefits provided. On the other hand, fixed-amount cost-sharing requirements (such as copayments and deductibles) do not take into account medical inflation. Therefore, changes to fixed-amount cost-sharing requirements (for example, moving from a $35 copayment to a $40 copayment for outpatient doctor visits) may be reasonable to keep up with the rising cost of medical items and services. Accordingly, paragraph (g)(1)(ii) provides that any increase in a percentage cost-sharing 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 requirements other than copayments and a rule for copayments. Fixed-amount cost-sharing requirements include, for example, a $500 deductible, a $30 copayment, or a $2,500 out-of-pocket limit. With respect to fixed-amount cost-sharing requirements other than copayments, a plan or health insurance coverage ceases to be a grandfathered health plan if there is an increase, since March 23, 2010, in a fixed-amount cost-sharing requirement that is greater than the maximum percentage increase. The maximum percentage increase is defined as medical inflation (from March 23, 2010) plus 15 percentage points. For this purpose, medical inflation is defined in these interim final regulations by reference to the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted (CPI), published by the Department of Labor. For fixed-amount copayments, a plan or health insurance coverage ceases to be a grandfathered health plan if there is an increase since March 23, 2010 in the copayment that exceeds the greater of (A) the maximum percentage increase or (B) five dollars increased by medical inflation. A more detailed description of the 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 cessation of grandfather status. Specifically, paragraph (g)(1)(v) limits the ability of an employer or employee organization to decrease its contribution rate for coverage under a group health plan or group health insurance coverage. Two different situations are addressed. First, if the contribution rate is based on the cost of coverage, a group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals[6] by more than 5 percent-

[6] Similarly situated individuals are described in the HIPAA nondiscrimination regulations at 26 CFR 54.9802–1(d), 29 CFR 2590.702(d), and 45 CFR 146.121(d).

age points below the contribution rate on March 23, 2010. For this purpose, contribution rate is defined as the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. These interim final regulations provide that total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions of section 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, contributions by an employer or employee organization are calculated by subtracting the employee contributions towards the total cost of coverage from the total cost of coverage. Second, if the contribution rate is based on a formula, such as hours worked or tons of coal mined, a group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percent below the contribution rate on March 23, 2010.

Finally, paragraph (g)(1)(vi) addresses the imposition of a new or modified annual limit by a plan, or group or individual health insurance coverage.[7] 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 dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits.
- A plan or health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an 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 benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

Under these interim final regulations, changes other than the changes described in 26 CFR 54.9815–1251T(g)(1), 29 CFR 2590.715–1251(g)(1), and 45 CFR 147.140(g)(1) will not cause a plan or coverage to cease to be a grandfathered health plan. Examples include changes to premiums, changes to comply with Federal or State legal requirements, changes to voluntarily comply with provisions of the Affordable Care Act, and changing 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 Affordable Care Act pursuant to a legally binding contract entered into prior to enactment, made changes to the terms of health insurance coverage pursuant to a filing before March 23, 2010 with a State insurance department, or made changes pursuant to written amendments to a plan that were adopted prior to March 23, 2010. If a plan or issuer makes changes in any of these situations, the changes are effectively considered part of the plan terms on March 23, 2010 even though they are not then effective. Therefore, such changes are not taken into account in considering whether the plan or health 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 coverage on March 23, 2010, the date of enactment of the Affordable Care Act, the Departments considered whether they should provide a good faith compliance period from Departmental enforcement until guidance regarding the standards for maintaining grandfather status was made available to the public. Group health plans and health insurance issuers often make routine changes from year to year, and some plans and issuers may have needed to 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 reasonable interpretation of the statutory requirements and may disregard changes to plan and policy terms that only modestly exceed those changes described in paragraph (g)(1) 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 date the regulations were made publicly available.

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

While the Departments have determined that the changes identified in paragraph (g)(1) of these interim final regulations would cause a group health plan or health insurance coverage to cease to be a grandfathered health plan, the Departments invite comments from the public on

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

whether this list of changes is appropriate and what other changes, if any, should be added to this list. Specifically, the Departments invite comments on whether the following changes should result in cessation of grandfathered health plan status for a plan or health insurance coverage: (1) changes to plan structure (such as switching from a health reimbursement arrangement to major medical coverage or from an insured product to a self-insured product); (2) changes in a network plan's provider network, and if so, what magnitude of changes would have to be made; (3) changes to a prescription drug formulary, and if so, what magnitude of changes would have to be made; or (4) any other substantial change to the overall benefit design. In addition, the Departments invite comments on the specific standards included in these interim final regulations on benefits, cost sharing, and employer contributions. The Departments specifically invite comments on whether these standards should be drawn differently in light of the fact that changes made by the Affordable Care Act may alter plan or issuer practices in the next several years. Any new standards published in the final regulations that are more restrictive than these interim final regulations would only apply prospectively to changes to plans or health insurance 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 to clarify or interpret the rules contained in these interim final regulations for maintaining grandfathered health plan status prior to the issuance of final regulations. The ability to issue prompt, clarifying guidance is especially important given the uncertainty as to how plans or issuers will alter their plans or policies in response to these rules. This guidance can address unanticipated changes by plans and issuers to ensure that individuals benefit from the Affordable Care Act's new health care protections while preserving the ability to maintain the coverage individuals had on the date of enactment.

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, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the 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 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815. The rules set forth in these interim final regulations govern the applicability of the requirements in these sections and are therefore appropriate to carry them out. Therefore, the foregoing interim final rule authority 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 proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. However, even if the APA were applicable, the Secretaries have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final regulations in place until a full public notice and comment process was completed. As noted above, numerous provisions of the Affordable Care Act are applicable for plan years (in the individual market, policy years) beginning on or after September 23, 2010, six months after date of enactment. Grandfathered health plans are exempt from many of these provisions while group health plans and group and individual health insurance coverage that are not grandfathered health plans must comply with them. The determination of whether a plan or health insurance coverage is a grandfathered health plan 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 affected by grandfather status would not allow sufficient time for the Departments to draft and publish proposed regulations, receive and consider comments, and draft and publish final regulations. Moreover, regulations are needed well in advance of the effective date of the requirements of the Affordable Care Act. Many group health plans and health insurance coverage that are not grandfathered health plans must make significant changes in their provisions to comply with the requirements of the Affordable Care Act. Moreover, plans and issuers considering other modifications to their terms need to know whether those modifications will affect their status as grandfathered health plans. Accordingly, in order to allow plans and health insurance coverage to be designed and implemented on a timely basis, regulations must be published and available to the public well in advance of the effective date of the requirements of the Affordable Care Act. It is not possible to have a full notice and comment process and to publish final regulations in the brief time 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 Affordable Care Act protect significant rights of plan participants and beneficiaries and individuals covered by individual health insurance policies and it is essential that participants, beneficiaries, insureds, plan sponsors, and issuers have certainty about their rights and responsibilities. Proposed regulations are not binding and cannot provide the necessary certainty. By contrast, the interim final regulations provide the public with an opportunity for comment, but 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 engage in full notice and comment rulemaking before putting these regulations into effect, and that it is in the public interest to promulgate interim final regulations.

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 modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act. Pursuant to section 1251, certain provisions of the Affordable Care Act do not apply to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010 (a grandfathered health plan).[8] The statute and these interim final regulations allow family members of individuals already enrolled in a grandfathered health plan to enroll in the plan after March 23, 2010; in such cases, the plan or coverage is also a grandfathered health plan with respect to the family members. New employees (whether newly hired or newly enrolled) and their families can enroll in a grandfathered group health plan after March 23, 2010 without affecting status as a grandfathered health plan.[9]

As addressed earlier in this preamble, and further discussed below, these interim final regulations include rules for determining whether changes to the terms of a grandfathered health plan made by issuers and plan sponsors allow the plan or health insurance coverage to remain a grandfathered 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 and some of the transfers 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 Management and Budget (OMB). Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determined that this regulation is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an annual effect on the economy of $100 million in any one year. Accordingly, OMB has reviewed these rules pursuant to the Executive Order. The Departments provide an assessment of the potential costs, benefits, and transfers associated with these interim final regulations below. The Departments invite comments on this 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 Affordable Care Act and section 2301 of the Reconciliation Act, provides that grandfathered health plans are subject only to certain provisions of the Affordable Care Act. The statute, however, is silent regarding changes plan sponsors and issuers can make to plans and health insurance coverage while retaining grandfather status. These interim final regulations are necessary in order to provide rules that plan sponsors and issuers can use to determine which changes they can make to the terms of the plan or health insurance coverage while retaining their grandfather status, thus exempting them from certain provisions of the Affordable Care Act and fulfilling a goal of the legislation, which is to allow those that like their healthcare to keep it. These interim final regulations are designed to allow individuals who wish to maintain their current health insurance plan to do so, to reduce short term disruptions in the 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 sought to provide adequate flexibility to plan sponsors and issuers to ease transition and mitigate potential premium increases while avoiding excessive flexibility that would conflict with the goal of permitting individuals who like their healthcare to keep it and might lead to longer term market segmentation as the least costly plans remain grandfathered the longest. In addition, the Departments recognized that many plan sponsors and issuers make changes to the terms of plans or health insurance coverage on an annual basis: premiums fluctuate, provider networks and drug formularies change, employer and employee contributions and cost-sharing change, and covered items and services may vary. Without some ability to make some adjustments while retaining grandfather status, the ability of individuals to maintain their current coverage would be frustrated, because most plans or health insurance coverage would quickly cease to be regarded as the same group health plan or health insurance coverage in existence on March 23, 2010. At the same

[8] The Affordable Care Act adds section 715(a)(1) to ERISA and section 9815(a)(1) to the Code to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes. Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the date of enactment (that is, grandfathered health plans) are only subject to certain provisions.

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

time, allowing unfettered changes while retaining grandfather status would also be inconsistent with Congress's intent to preserve 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 reasonable changes routinely made by plan sponsors or issuers without the plan or health insurance coverage relinquishing its grandfather status so that individuals can retain the ability to remain enrolled in the coverage in which they were enrolled on March 23, 2010. Thus, for example, these interim final regulations generally permit plan sponsors and issuers to make voluntary changes to increase benefits, to conform to required legal changes, and to adopt 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 the costs and benefits of potentially effective and reasonable alternatives to the planned regulation, and an explanation of why the planned regulatory action is preferable to the potential alternatives. The alternatives considered by the Departments fall into two general categories: permissible changes to cost sharing and 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, the data analysis led the Departments to believe that the cost-sharing windows provided in these interim final regulations permit enough flexibility to enable a smooth transition in the group market over time, and further widening this window was not necessary and could conflict with the goal of allowing those who like their healthcare to keep it.

Another alternative the Departments considered was an annual allowance for cost-sharing increases above medical inflation, as opposed to the one-time allowance of 15 percent above medical inflation. An annual margin of 15 percent above medical inflation, for example, would permit plans to increase cost sharing by medical inflation plus 15 percent every year. The Departments concluded that the effect of the one-time allowance (15 percent of the original, date-of-enactment level plus medical inflation) would diminish over time insofar as it would represent a diminishing fraction of the total level of cost sharing with the cumulative effects of medical inflation over time. Accordingly, the one-time allowance would better reflect (i) the potential need of grandfathered health plans to make adjustments in the near term to reflect the requirement that they comply with the market reforms that apply to grandfathered health plans in the near term as well as (ii) the prospect that, for many plans and health insurance coverage, the need to recover the costs of compliance in other ways will diminish in the medium term, in part because of the changes that will become effective in 2014 and in part because of the additional time plan sponsors and issuers will have to make gradual adjustments that take into account the market reforms that are due to take effect in later years.

The Departments considered establishing an overall prohibition against changes that, in the aggregate, or cumulatively over time, render the plan or coverage substantially different than the plan or coverage that existed on March 23, 2010, or further delineating other examples of changes that could cause a plan to relinquish grandfather status. This kind of "substantially different" standard would have captured significant changes not anticipated in the interim final regulation. However, it would rely on a "facts and circumstances" analysis in defining "substantially different" or "significant changes," which would be less transparent and result in greater uncertainty about the status of a health plan. That, in turn, could hinder plan sponsor or issuer 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 coverage to retain status as a grandfathered health plan if the actuarial value of the coverage remains in approximately the same range as it was on March 23, 2010. However, under such a standard, a plan could make fundamental changes to the benefit design, potentially conflicting with the goal of allowing those who like their healthcare to keep it, and still retain grandfather status. Moreover, the complexity involved in defining and determining actuarial value for these purposes, the likelihood of varying methodologies for determining such value unless the Departments promulgated very detailed prescriptive rules, and the costs of administering and ensuring compliance with such rules led the Departments to reject that approach.

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

The Departments also considered whether a change in third party administrator by a self-insured plan should cause the plan to relinquish grandfather status. The Departments decided that such a change would not necessarily cause the plan to be so different from the plan in effect on March 23, 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 grandfather status if only relatively small changes are made to the plan. The Departments concluded that plan sponsors and issuers of grandfathered health plans should be permitted to take steps within the boundaries of the grandfather definition to control costs, including limited increases in cost-sharing and other plan changes not prohibited by these interim final regulations. As noted earlier, deciding to relinquish grandfather status is a one-way sorting process: after some period of time, more plans will relinquish their grandfather status. These interim final regulations will likely influence plan sponsors' 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 coverage no longer will be 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 necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition;
- Increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on March 23, 2010;
- Increases fixed-amount cost-sharing requirements other than copayments, such as a $500 deductible or a $2,500 out-of-pocket limit, by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation and 15 percentage points.[10]
- Increases copayments by an amount that exceeds the greater of: a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percentage points, or $5 increased by medical inflation measured from March 23, 2010;
- For a group health plan or group health insurance coverage, an employer or employee organization decreases its contribution rate by more 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 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits imposes an overall annual limit on the dollar value of benefits; (2) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010; or (3) a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits).

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

In accordance with OMB Circular A–4,[11] Table 2 below depicts an accounting statement showing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action. In accordance with Executive Order 12866, the Departments believe that the benefits of 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 grandfather status. Non-grandfathered plans are required to offer coverage with minimum benefit standards and patient protections as required by the Affordable Care Act, while grandfathered plans are required only to comply with certain provisions. The existence of grandfathered health plans will provide individuals with the benefits of plan continuity, which may have a high value to some. In addition, grandfathering could potentially slow the rate of premium growth, depending on the extent to which their current plan does not include the benefits and protections of the new law. It could also provide incentives to employers to continue coverage, potentially reducing new Medicaid enrollment and spending and lowering the number of uninsured individuals. These interim final regulations also provide greater certainty for plans and issuers about what changes they can make without affecting their grandfather status. As compared with alternative approaches, these regulations provide significant economic and noneconomic benefits to both 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	Period Covered
Annualized	22.0	25.6	27.9	2010	7%	2011–2013
Monetized ($millions/year)	21.2	24.7	26.9	2010	3%	2011–2013

Monetized costs are due to a requirement to notify participants and beneficiaries of a plan's grandfather status and maintain plan documents to 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 grandfathered health plans increasing more (or decreasing less) than they otherwise would. This increased cost may encourage some sponsors and issuers to replace their grandfathered health plans with new, non-grandfathered ones. Market segmentation (adverse selection) due to the decision of higher risk plans to relinquish grandfathering could cause premiums in the exchanges to be higher than they would have been absent grandfathering.

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

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

Transfers

Qualitative: Limits on the changes to cost-sharing in grandfathered plans and the elimination of cost-sharing for some services in non-grandfathered plans, leads to transfers of wealth from premium payers overall to individuals using covered services. Once pre-existing conditions are fully prohibited and other insurance reforms take effect, the extent to which individuals are enrolled in grandfathered plans could affect adverse selection, as higher risk plans relinquish grandfather status to gain new protections while lower risk grandfathered plans retain their grandfather 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 those covered under these plans and health insurance coverage. The collective decisions of plan sponsors and issuers over time can be viewed as a one-way sorting 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 grandfather status;
2. Significantly change the terms of the plan or coverage and comply with Affordable Care Act provisions from which grandfathered health plans 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 may be one consideration in making its decisions. To determine the value of retaining the health plan's grandfather status, each plan sponsor or issuer must determine whether the rules applicable to grandfathered health plans are more or less favorable than the rules applicable to non-grandfathered health plans. This determination will depend on such factors as the respective prices of grandfathered and non-grandfathered health plans, as well as on the preferences of grandfathered health plans' covered populations and their willingness to pay for benefits and patient protections available under non-grandfathered health plans. In making its decisions about grandfather status, a plan sponsor or issuer is also likely to consider the market segment (because different rules apply to the large and small group market segments), and the utilization pattern of its covered population.

In deciding whether to change a plan's benefits or cost sharing, a plan sponsor or issuer will examine its short-run business requirements. These requirements are regularly altered by, among other things, rising costs that result from factors such as technological changes, changes in risk status of the enrolled population, and changes in utilization and provider prices. As shown below, changes in benefits and cost sharing are typical in insurance markets. Decisions about the extent of changes will determine whether a plan retains its grandfather status. Ultimately, these decisions will involve a comparison by the plan sponsor or issuer of the long run value of grandfather status to the short-run need of that plan sponsor or issuer to 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, especially a tendency among many towards inertia and resistance to change. There is limited research that has directly examined what drives this tendency — whether individuals remain with health plans because of simple inertia and procrastination, a lack of relevant information, or because they want to avoid risk associated with switching to new plans. One study that examined the extent to which premium changes influenced plan switching determined that younger low-risk employees were the most price-sensitive to premium changes; older, high-risk employees were the least price-sensitive. This finding suggests that, in particular, individuals with substantial health needs may be more apt to remain with a plan because of inertia as such or uncertainties associated with plan switching rather than quality per se — a phenomenon some behavioral economists have called "status quo bias,"[12] which can 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 change because of inertia, a lack of relevant information, or because of the cost and effort involved in examining new options and uncertainty about the alternatives. Consistent with well-known findings in behavioral economics, studies of private insurance demonstrate the substantial effect of inertia in the behavior of the insured. One survey found that approximately 83 percent of privately insured individuals stuck with their plans in the year prior to the survey.[13] Among those who did change plans, well over half sought the same type of plan they had before. Those who switched plans also tended to do so for reasons other than preferring their new plans. For example, many switched because they changed jobs or their employer changed insurance offerings, compelling them to switch.

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

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

[13] *http://content.healthaffairs.org/cgi/reprint/19/3/158.pdf* "Health Plan Switching: Choice Or Circumstance?" (Cunnigham and Kohn, 2000).

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

on the satisfaction of the insured with their health plans.[15]

The incentives to change are different for people insured in the individual market than they are for those covered by group health plans or group health insurance coverage. The median length of coverage for people entering the individual market is eight months.[16] In part, this "churn" stems from the individual market's function as a stopping place for people between jobs with employer-sponsored or other types of health insurance, but in part, the churn is due to the behavior of issuers. Evidence suggests that issuers often make policy changes such as raising deductibles as a means of attracting new, healthy enrollees who have few medical costs and so are little-concerned about such deductibles. There is also evidence that issuers use such changes to sort out high-cost enrollees from low-cost ones.[17]

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

A similar analysis applies to the provision that an employer's or employee organization's share of the total premium of a group health plan cannot be reduced by more than 5 percentage points from the share it was paying on March 23, 2010 without that plan or health insurance coverage relinquishing its grandfather status. Employers and employee organizations sponsoring group health plans or health insurance coverage may be faced with economic circumstances that would lead them to reduce their premium contributions. But reductions of greater than 5 percentage points would cause them to relinquish the grandfather status of their plans. These plan sponsors must decide whether the benefit of such premium 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 individual and small group policies. Small groups for this purpose include employers with up to 100 employees (States may limit this threshold to 50 employees until 2016). The Affordable Care Act rating rules will not apply to grandfathered health plans, but such plans will remain subject to State rating rules, which vary widely and typically apply to employers with up to 50 employees. Based on the current State rating rules, it is likely that, in many States, no rating rules will apply to group health insurance policies that are grandfathered health plans covering employers with 51 to 100 employees.[18]

The interaction of the Affordable Care Act and State rating rules implies that, beginning in 2014, premiums can vary more widely for grandfathered plans than for non-grandfathered plans for employers with up to 100 employees in many States. This could encourage both plan sponsors and issuers to continue grandfathered health plans that cover lower-risk groups, because these groups will be isolated from the larger, higher-risk, non-grandfathered risk pool. On the other hand, this scenario likely will encourage plan sponsors and issuers that cover higher-risk groups to end grandfathered health plans, because the group would be folded into the larger, lower-risk non-grandfathered pool. Depending on the size of the grandfathered health plan market, such adverse selection by grandfathered health plans against non-grandfathered plans could cause premiums in the exchanges to be higher than they would have been absent grandfathering. To accommodate these changes in market dynamics in 2014, the Departments have structured a cost-sharing rule whose parameters enable greater flexibility in early years and less over time. It is likely that few plans will delay for many years before making changes that exceed medical inflation. This is because the cumulative increase in copayments from March 23, 2010 is compared to a maximum percentage increase that includes a fixed amount — 15 percentage points — that does not increase annually with any type of inflator. This should help mitigate adverse selection and require plans and issuers that seek to maintain grandfather status to find ways other than increased copayments to limit cost growth. As discussed in the preamble, the Departments are also soliciting comments to make any adjustments needed for the final rule prior to 2014. Therefore it is premature to estimate the economic effects described above in 2014 and beyond. In the following section, the Departments provide a range of estimates of how issuers and sponsors might respond to these interim final regulations, with the caveat that there is substantial uncertainty about actual outcomes, especially considering that available data are historical and 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 large and small group markets will be discussed first, followed by a discussion of impacts on the individual market. The Departments have defined a large group health plan 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

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

[16] Erika C. Ziller, Andrew F. Coburn, Timothy D. McBride, and Courtney Andrews. Patterns of Individual Health Insurance Coverage, 1996–2000. *Health Affairs* Nov/Dec 2004: 210–221.

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

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

100 workers. Using data from the 2008 Medical Expenditure Survey — Insurance Component, the Departments estimated that there are approximately 72,000 large ERISA-covered health plans and 2.8 million small group health plans with an estimated 97.0 million participants and beneficiaries[19] in large group plans and 40.9 million participants and beneficiaries in small group plans. The Departments estimate that there are 126,000 governmental plans[20] with 36.1 million participants in large plans and 2.3 million participants in small plans. The Departments estimate there are 16.7 million individuals under age 65 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 that plans made between plan years 2007 to 2008 and 2008 to 2009. Specifically, the Departments examined changes made to deductibles, out-of-pocket maximums, copayments, coinsurance, and the employer's share of the premium or cost of coverage. The Departments also estimated the number of fully-insured plans that changed issuers.[21] The distribution of changes made within the two time periods were nearly identical and ultimately the 2008–2009 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 maintaining grandfather status with the need to meet short run objectives by changing plan features including the various cost sharing requirements that are the subject of this rule. The 2008–2009 data reflect changes in plan benefit design that were made under very different market conditions and expectations than will exist in 2011 and beyond. Therefore, there is a significant degree of uncertainty associated with using the 2008–2009 data to project the number of plans whose grandfather status may be affected in the next few years. Because the level of uncertainty becomes substantially greater when trying to use this data to predict outcomes once the full range of reforms takes effect in 2014 and the exchanges begin operating, substantially changing market dynamics the Departments restrict our estimates to the 2011–2013 period and use the existing data and a range of assumptions to estimate possible outcomes based on a range of assumptions concerning how plans' behavior regarding cost sharing changes may change relative to what is reflected in the 2008–2009 data.

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

- Using Kaiser/HRET data for 2008–2009, estimates were generated of the number of plans in the large and small group markets that made changes in employer premium share or any of the cost-sharing parameters that were larger than permitted for a plan to retain grandfather 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, the Departments assumed that many plans will want to maintain grandfather status and will look for ways to achieve short run cost control and still maintain that status. One plausible assumption is that plans would look to a broader range of cost sharing strategies in order to achieve cost containment and other objectives than they had in the past. In order to examine this possibility, the Departments carefully analyzed those plans that would have relinquished grandfather status based on a change they made from 2008–2009. The Departments then estimated the proportion of these plans that could have achieved similar cost control by using one or more other cost-sharing changes in addition to the one they made in a manner that would not have exceeded the limits set by these interim final regulations for qualifying as a grandfathered health plan. For example, if a plan was estimated to relinquish grandfather status because it increased its deductible by more than the allowed 15 percentage points plus medical inflation, the Departments analyze whether the plan could have achieved the same cost control objectives with a smaller change in deductible, but larger changes (within the limits set forth in these interim final regulations) in copayments, out-of-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 possible that some sponsors who made changes from 2008–2009 in plan parameters that were so large that they would have relinquished their grandfather status would not make similar changes in 2011–2013. It is also possible that even though a sponsor could make an equivalent change that conforms to the rules established in these interim final regulations to maintain grandfather status, it would decide not to.

The estimates in this example rely on several other assumptions. Among them: (1) the annual proportion of plans relinquishing grandfather status is the same throughout the period; (2) all group health plans existing at the beginning of 2010 qualify for grandfather status; (3) all changes during 2010 occur after March 23, 2010; (4) annual medical inflation is 4 percent (based on the average annual change in the medical CPI between 2000 and 2009); and (5) firms for which the Kaiser-HRET survey has data for both 2008 and 2009 are representative of all

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

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

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

firms.[22] The assumption used for estimating the effects of the limits on copayment increases does not take into account the greater flexibility in the near term than in the long term; the estimated increase in firms losing their grandfather status over time reflects cumulative effects of a constant policy. To the extent that the data reflect plans that are more likely to make frequent changes in cost sharing, the assumption that a constant share of plans relinquishing grandfather status throughout the period may underestimate the number of plans that will retain grandfather status through 2013. In addition, data on substantial benefit changes were not available and thus not included in the analysis. The survey data is limited, in that it covers only one year of changes in healthcare plans. The Departments' analysis employed data only on PPO plans, the predominant type of plan. In addition, the difficulties of forecasting behavior in response to this rule create uncertainties for quantitative evaluation. However, the analysis presented here is illustrative of the rule's goal 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, copayments, or out-of-pocket maximums that exceeded 19 percent (the sum of medical inflation (assumed in these analyses to be four percent) plus 15 percentage points measured from March 23, 2010. Plans making copayment changes of five dollars or less were considered to have satisfied the copayment limit, even if that change exceeded 19 percent.[23] The Departments also estimated the number of plans for whom the percentage of total premium paid by the employer declined by more than 5 percentage points. For fully-insured plans only, estimates were made of the proportion that switched to a different issuer.[24] This estimate does not take into account collectively bargained plans, which can change issuers during the period of the collective bargaining agreement without a loss of grandfather status, because the Departments could not quantify this category of plans. Accordingly, this estimate represents an upper bound.

Using the Kaiser/HRET data, the Departments estimated that 55 percent of small employers and 36 percent of large employers made at least one change in cost-sharing parameters above the thresholds provided in these interim final regulations. Similarly, 33 percent of small employers and 21 percent of large employers decreased the employer's share of premium by more than five percentage points. In total, approximately 66 percent of small employers and 48 percent of large employers made a change in either cost sharing or premium contribution during 2009 that would require them to relinquish grandfather status if the same change were made in 2011.[25]

The changes made by employers from 2008 to 2009 were possibly made in anticipation of the recession. As discussed previously, analysis of changes from 2007 to 2008 suggests that the 2007–08 changes were not much different from the 2008–09 changes. Nevertheless, as a result of improvements in economic conditions, it makes sense to think that the pressure on employers to reduce their contributions to health insurance will be smaller in 2011 than they were in 2009, and that the Department's analysis of changes in 2009 may overestimate the changes that should be expected in 2011.[26]

As discussed previously, it is highly unlikely that plans would continue to exhibit the same behavior in 2011 to 2013 as in 2008 to 2009. In order to guide the choice of behavioral assumptions, the Departments conducted further analyses of the 2008–2009 data. Many employers who made changes between 2008 and 2009 that would have caused them to relinquish grandfather status did so based on exceeding one of the cost-sharing limits. Assuming that the sponsor's major objective in implementing these changes was to restrain employer costs or overall premiums, the Departments examined whether the sponsor could have achieved the same net effect on employer cost or premiums by spreading cost sharing over two or more changes without exceeding the limits on any of these changes. For example, an employer that increased its deductible by 30 percent would have relinquished grandfather status. However, it is possible that the employer could have achieved the same cost control objectives by limiting the deductible increase to 19 percent, and, also increasing the out-of-pocket maximum or copayments, or decreasing the employer share of the premium.

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

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

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

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

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

[26] Employers who offer plans on a calendar year basis generally make decisions about health plan offerings during the preceding summer. Thus, decisions for calendar 2009 were generally made during the summer of 2008. At that time, the depth of the coming recession was not yet clear to most observers.

For fully insured group health plans, another change that would require a plan to relinquish grandfather status is a change in issuer. Between 2008 and 2009, 15 percent of small employers and four percent of large employers changed insurance carriers.[27] However, it is likely that the incentive to stay grandfathered would lead some of these employers to continue with the same issuer, making the actual share of firms relinquishing grandfather status as a result of an issuer change lower than the percentage that switched in 2009. There appears to be no empirical evidence to provide guidance on the proportion of employers that would choose to remain with their issuer rather than relinquish grandfather status. That being so, an assumption was made that 50 percent of employers that changed issuers in 2009 would not have made a similar change in 2011 in order to retain grandfather status. It is likely that fewer employers will elect to change carriers than in recent years given that some will prefer to retain grandfather status. But it is also likely that many employers will prefer to switch carriers given a change in the issuer's network or other factors. Because there is little empirical evidence regarding the fraction of firms that would elect to switch in response to the change in regulations, we take the midpoint of the plausible range of no switching carriers at one extreme and all switching carriers at the other extreme. We therefore assume that 50 percent of 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 make cost-sharing, benefit or employer contribution changes beyond the permitted parameters with the estimates of the percentage that would relinquish grandfather status because they change issuers, the Departments estimate that approximately 31 percent of small employers and 18 percent of large employers would make changes that would require them to relinquish grandfather status in 2011. The Departments use these estimates as our mid-range scenario.

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

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

To examine the impact of this type of behavior on the estimates on the number of plans that would not maintain grandfather status, the Departments examined the magnitude of additional premium increases plans would need to implement if they were to modify their cost-sharing changes to stay within the allowable limits. Among the 24 percent of small firms that would have relinquished grandfather status based on the changes they made in 2009, 31 percent would have needed to increase premiums by 3 percent or less in order to maintain grandfather status. The analogous statistic for the 16 percent of large firms that would have relinquished grandfather status is 41 percent. It is reasonable to think that employers that are facing 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 percent more than their otherwise intended level (or can make changes to benefits other than cost-sharing that achieve a similar result), then 14 percent of small employers and 11 percent of large employers would relinquish grandfather status if they made the same changes in 2011 as they had in 2009. Adding in the employers who would relinquish grandfather status because they change issuers, the Departments' lower bound estimate is that approximately 21 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 of the 2009 data, there are other factors that may cause the Departments' estimates of the fraction of plans retaining grandfather status to be overestimates of the fraction that will retain grandfather status. The estimates are based on the assumption that all plans that could accommodate the 2009 change they made in a single cost-sharing parameter by spreading out those changes over multiple parameters would actually do so. However, some plans and sponsors may be concerned about the labor relations consequences of reducing the employer contribution to premium. For example, if a plan increases its out-of-pocket maximum from $3,000 to $5,000 in 2009, it could choose to remain grandfathered by limiting the out-of-pocket maximum to $3,570, reducing the employer contribution and increasing the employee contribution to premium. It is not clear, however, that all plan sponsors would do so — some may see the costs in negative employee relations as larger than the benefits from remaining grandfathered. Moreover, because some plans may already nearly comply with all provisions of the Affordable Care Act, or because enrollees are of average to less favorable health status, some 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 in cost-sharing parameter that could not be accommodated without reducing the employer contribution will be

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

unwilling to reduce the employer contribution as a share of premium. Under this assumption, the 24 percent and 16 percent estimates of the proportion of employers relinquishing grandfather status increases to approximately 37 percent and 28 percent among small and large employers, respectively. Adding in the number of employers that it is estimated will change issuers, the Departments' high-end estimate for the proportion that will relinquish grandfather status in 2011 is approximately 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 extended through 2013 by assuming that the identical percentage of plan sponsors will relinquish grandfathering in each year. Again, to the extent that the 2008–2009 data reflect plans that are more likely to make frequent changes in cost sharing, this assumption will overestimate the number of plans relinquishing 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 large employer plans will relinquish their grandfather status by the end of 2013. The low-end estimates are for 49 percent and 34 percent of small and large employer plans, 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 Status, 2011–2013*

	2011	2012	2013
Low-end Estimate			
Small Employer Plans	20%	36%	49%
Large Employer Plans	13%	24%	34%
All Employer Plans	**15%**	**28%**	**39%**
Mid-range Estimate			
Small Employer Plans	30%	51%	66%
Large Employer Plans	18%	33%	45%
All Employer Plans	**22%**	**38%**	**51%**
High-end Estimate			
Small Employer Plans	42%	66%	80%
Large Employer Plans	29%	50%	64%
All Employer Plans	**33%**	**55%**	**69%**

Notes: Represents full-time employees. Small Employers=3 to 99 employees; Large Employers=100+ employees. All three scenarios assume that two percent of all large employer plans and six percent of small employer plans would relinquish grandfathered status due to a change in issuer. 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 proportion of plans that will remain grandfathered until 2014. As mentioned previously, the individual market is a residual market for those who need insurance but do not have group coverage available and do not qualify for public coverage. For many, the market is transitional, providing a bridge between other types of coverage. One study found a high percentage of individual insurance policies began and ended with employer-sponsored coverage.[28] More importantly, coverage on particular policies tends to be for short periods of time. Reliable data are scant, but a variety of studies indicate that between 40 percent and 67 percent of policies are in effect for less than one year.[29] Although data on changes in benefit packages comparable to that for the group market is not readily available, the high turnover rates described here would dominate benefit changes as the chief source of changes in grandfather status.

While a substantial fraction of individual policies are in force for less than one year, a small group of individuals maintain their policies over longer time periods. One study found that 17 percent of individuals maintained their policies for more than two years,[30] while another found that nearly 30 percent maintained policies for more than three years.[31]

Using these turnover estimates, a reasonable range for the percentage of individual policies that would terminate, and therefore relinquish their grandfather status, is 40 percent to 67 percent. These estimates assume that the policies that terminate are replaced by new individual policies, and that these new policies are not, by definition, grandfathered. In addition, the coverage that some individuals maintain for long periods might lose its grandfather

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

[29] Ibid.

[30] *http://content.healthaffairs.org/cgi/content/full/23/6/210#R14* "Patterns of Individual Health Insurance Coverage" *Health Affairs* (Ziller et al, 2004).

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

status because the cost-sharing parameters in policies change by more than the limits specified in these interim final regulations. The frequency of this outcome cannot be gauged due to lack of data, but as a result of it, the Departments estimate that the percentage of individual market policies losing grandfather status in a given year exceeds the 40 percent to 67 percent range that is estimated based on the fraction of 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 provisions. One such provision is the requirement that, in plan years on or after September 23, 2010, but prior to January 1, 2014, grandfathered group health plans are required to offer dependent coverage to a child under the age of 26 who is not eligible for employer-sponsored insurance. In the Regulatory Impact Assessment (RIA) for the regulation that was issued on May 13, 2010 (75 FR 27122), the Departments estimated that there were 5.3 million young adults age 19–25 who were covered by employer-sponsored coverage (ESI) and whose parents were covered by employer-sponsored insurance, and an additional 480,000 young adults who were uninsured, were offered ESI, and whose parents were covered by ESI. In that impact assessment, the Departments assumed that all parents with employer-sponsored insurance would be in grandfathered health plans, and that none of their 19–25 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, leaving approximately 20 percent of these parents in non-grandfathered health plans. Young adults under 26 with employer-sponsored insurance or with an offer of such coverage whose parents are in non-grandfathered plans potentially could enroll in their parents' coverage. The Departments assume that a large percentage of the young adults who are uninsured will enroll in their parents' coverage when given the opportunity. It is more difficult to model the choices of young adults with an offer of employer-sponsored insurance whose parents also have group coverage. One assumes these young adults will compare the amount that they must pay for their own employer's coverage with the amount that they (or their parents) would pay if they were covered under their parents' policies. Such a decision will incorporate the type of plan that the parent has, since if the parent already has a family plan whose premium does not vary by number of dependents, the adult child could switch at no additional cost to the parents. A very rough estimate therefore is that approximately 25 percent of young adults with ESI will switch to their parents' coverage when their parents' coverage is not grandfathered. The Departments assume that 15 percent of young adults who are offered ESI but are uninsured and whose parents have non-grandfathered health plans will switch to their parents' plan. This latter estimate roughly corresponds to the assumption made in the low-take up rate 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 will be covered by their parents' health coverage in 2011, of whom 14,000 would have been uninsured, compared with the dependent coverage regulation impact analysis that assumed that all existing plans would have remained grandfathered and none of these adult children would have been eligible for coverage under their parents' plans. By 2013, an estimated 698,000 additional young adults with ESI or an offer of ESI will be covered by their parent's non-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 that document the plan or policy terms in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify is status as a grandfathered health plan. The records must be made available for examination by participants, beneficiaries, individual policy subscribers, or a 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 materials provided to participants or beneficiaries (in the individual market, primary subscriber) describing the benefits provided under the plan or health insurance coverage, and that the plan or coverage is intended to be a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act. In these interim final regulations, the Departments provide a model statement plans and issuers may use to satisfy the disclosure requirement. The Department's estimate that the one time cost to plans and insurance issuers of preparing and distributing the grandfathered health plan disclosure is $39.6 million in 2011. The one time cost to plans and insurance issuers for the record retention requirement is estimated to be $32.2 million in 2011. For a discussion of the grandfathered health plan document retention and disclosure requirements, see the Paperwork Reduction Act section later in 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 subject to the notice 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 economic impact on a substantial number of small entities. Under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. These interim final regulations are exempt from the APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments

are not required to either certify that the regulations would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the regulations on small entities in connection with their assessment under Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that suggest alternative 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 of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the Bulletin. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

E. *Paperwork Reduction Act*

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

As part of their continuing efforts to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance 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 provided in the desired format, reporting burden (time and financial resources) is minimized, collection requirements on respondents can be properly assessed.

As discussed earlier in this preamble, if a plan or health insurance coverage intends to be a grandfathered health plan, it must include a statement in any plan materials provided to participants or beneficiaries (in the individual market, primary subscriber) describing the benefits provided under the plan or health insurance coverage, and that the plan or coverage is intended to be grandfathered health plan within the meaning of section 1251 of the Affordable Care Act ("grandfathered health plan disclosure"). Model language has been provided in these interim final regulations, the use of 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 records documenting the plan or policy terms in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan ("recordkeeping requirement"). In addition, the plan or issuer must make such records available for examination. Accordingly, a participant, beneficiary, individual policy subscriber, or State or Federal agency official would be able to inspect such documents to 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 provisions. These interim regulations define for plans and issuers the scope of changes that they can make to their grandfathered health plans and policies under the Affordable Care Act while retaining their grandfathered health plan status.

The Affordable Care Act grandfathered health plan disclosure and recordkeeping requirements are information collection requests (ICR) subject to the PRA. Currently, the Departments are soliciting public comments for 60 days concerning these disclosures. The Departments have submitted a copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Departments and 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, including whether the 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 the methodology and 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 appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by fax to (202)395–7285 or by email to *oira_submission@omb.eop.gov*. A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N–5718, Washington, DC 20210. Telephone: (202) 693–8410; Fax: (202) 219–2745. These are not toll-free numbers. E-mail: *ebsa.opr@dol.gov*. ICRs submitted to OMB also are available at reginfo.gov (*http://www.reginfo.gov/public/do/PRAMain*).

a. Grandfathered health plan disclosure

In order to satisfy the interim final regulations' grandfathered health plan disclosure requirement, the Departments estimate that 2.2 million ERISA-covered plans will need to notify an estimated 56.3 million policy holders of their plans'

grandfathered health plan status.[32] The following estimates, except where noted, are based on the mid-range estimates of the percent of plans retaining grandfather status. Because the interim final regulations provide model language for this purpose, the Departments estimate that five minutes of clerical time (with a labor rate of $26.14/hour) will be required to incorporate the required language into the plan document and ten minutes of an human resource professional's time (with a labor rate of $89.12/hour) will be required to review the modified language.[33] After plans first satisfy the grandfathered health plan disclosure requirement in 2011, any additional burden should be *de minimis* if a plan wants to maintain its grandfather status in future years. The Departments also expect the cost of removing the notice from plan documents as plans relinquish their grandfather status to be *de minimis* and therefore is not estimated. Therefore, the Departments estimate that plans will incur a one-time hour burden of 538,000 hours with an equivalent cost of $36.6 million to meet the disclosure requirement.

The Departments assume that only printing and material costs are associated with the disclosure requirement, because the interim final regulations provide model language that can be incorporated into existing plan documents, such as a summary plan description (SPD). The Departments estimate that the notice will 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 delivered electronically. This results in a cost burden of $873,000 ($0.05 per page*1/2 pages per notice * 34.9 million notices*0.62).

b. Record-Keeping requirement

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

With an estimated 2.2 million grandfathered plans in 2011, the Departments estimate an hour burden of approximately 538,000 hours with equivalent costs of $30.7 million. The Departments have estimated this as a one-time cost incurred in 2011, because after the first year, the Departments 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 hour burden of 1.1 million 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 comply with, an ICR 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 Treasury.

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 Service).

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

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

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

a. Grandfathered health plan disclosure

In order to satisfy the interim final regulations' grandfathered health plan disclosure requirement, the Department estimates that 98,000 state and local governmental plans will need to notify approximately 16.2 million policy holders of their plans' status as a grandfathered health plan. The following estimates except where noted are based on the mid-range estimates of the percent of plans retaining grandfather status. An estimated 490 insurers providing coverage in the individual market will need to notify an estimated 4.3 million policy holders of their policies' status as a grandfathered health plan.[34]

Because the interim final regulations provide model language for this purpose, the Department estimates that five minute of clerical time (with a labor rate of $26.14/hour) will be required to incorporate the required language into the plan document and ten minutes of a human resource professional's time (with a labor

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

[33] EBSA estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

[34] The Department's estimate of the number of state and local governmental health plans was obtained from the 2007 Census of Governments. The estimate of the number of policy holders in the individual market were obtained from the 2009 Current Population Survey. The methodology used to estimate the percentage of state and local governmental plans and individual market policies that will retain their grandfathered health plan status was discussed above.

rate of $89.12/hour) will be required to review the modified language.[35] After plans first satisfy the grandfathered health plan disclosure requirement in 2011, any additional burden should be *de minimis* if a plan wants to maintain its grandfather status in future years. The Department also expects the cost of removing the notice from plan documents as plans relinquish their grandfather status to be *de minimis* and therefore is not estimated. Therefore, the Department estimates that plans and insurers will incur a one-time hour burden of 26,000 hours with an 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 interim final regulations provide model language that can be incorporated into existing plan documents, such as an SPD. The Department estimates that the notice will 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 delivered electronically. 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 recordkeeping requirement already are retained by plans for tax purpose, to satisfy ERISA's record retention and statute of limitations requirements, and for other business reasons. Therefore, the Department estimates that the recordkeeping burden imposed by this ICR will require five minutes of a legal professional's time (with a rate of $119.03/hour) to determine the relevant plan documents that must be retained and ten minutes of clerical staff time (with a labor rate of $26.14/hour) to organize and file the required documents to ensure that they are accessible to participants, beneficiaries, and Federal and State governmental agency officials.

With an estimated 98,000 grandfathered plans and 7,400 grandfathered individual insurance products[36] in 2011, the Department estimates an hour burden of approximately 26,000 hours with equivalent costs of $1.5 million. The Department's have estimated this as a one-time cost incurred in 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 hour burden of 53,000 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 comply with, an ICR 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 Enforcement Fairness Act of 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 before proposing any rules that may result in annual expenditures of $100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. These interim final regulations are not subject to the Unfunded Mandates Reform Act, because they are being issued as an interim final regulation. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, these interim final regulations have been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

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 federal agencies in the process of their formulation and implementation of policies that have ''substantial direct effects'' on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the 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

[35] EBSA estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

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

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

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be ''construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement'' of a federal standard. The conference report accompanying HIPAA indicates that this is intended to be the ''narrowest'' preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the federal requirements are unlikely to ''prevent the application of'' the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements. Throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the 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 regulations, the Departments certify that the Employee Benefits Security Administration and the Office of Consumer Information and Insurance Oversight have complied with the 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 9833 of the Code.

The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 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. 111–148, 124 Stat. 119, 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 sections 2701 through 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,
Secretary.

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 order to read in part as 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 coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage.

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

(2) *Disclosure of grandfather status*—(i) To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care 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" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. 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 health plan, or group health insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan —

(i) Maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and 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 health insurance coverage on March 23, 2010, grandfathered health plan coverage includes coverage of family members of the individual who enroll after March 23, 2010 in the 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 through a group health insurance policy from Issuer X on March 23, 2010. For the plan year beginning January 1, 2012, the plan enters into a new policy with Issuer Z.

(ii) *Conclusion*. In this *Example 1*, for the plan year beginning January 1, 2012, the group health insurance coverage issued by Z is not a grandfathered health plan under the rules of paragraph (a)(1)(ii) of this section because the policy issued by Z did not provide coverage on March 23, 2010.

Example 2. (i) *Facts*. A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan replaces the issuer for Option H with a new issuer.

(ii) *Conclusion*. In this *Example 2*, the coverage under Option H is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (a)(1)(ii) of this section. Whether the coverage under Options F and G is grandfathered health plan coverage is determined under the rules of this section, including paragraph (g) of this section. If the plan enters into a new policy, certificate, or contract of insurance for Option G, 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 health plan (including health insurance coverage provided in connection with the group health plan) that provided coverage on March 23, 2010 and has retained its status as a grandfathered health plan (consistent with the rules of this section, including paragraph (g) of this section) is grandfathered health plan coverage for 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 restructuring is to cover new 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 health plan) ceases to be a grandfathered health plan if —

(A) Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan or health insurance coverage under which 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 the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfather status under the provisions of paragraph (g)(1) of this section; and

(C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms or 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 subsequent open enrollment 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 under the rules of paragraph (b)(1) of this section because employees previously enrolled in Option F are allowed to enroll in Option G as new employees.

Example 2. (i) *Facts*. Same facts as *Example 1*, except that the plan sponsor eliminates Option F because of its high cost and transfers employees covered under Option F to Option G. If instead of transferring employees from Option F to Option G, Option F was amended to match the terms of 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 Option F to Option G. Therefore, Option G ceases to be a grandfathered health plan with respect to all employees. (However, any other benefit package maintained by the 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, 2010, Option H provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the closed plant are moved to another plant. The employer eliminates Option H and the employees that are moved are transferred to Option I. If instead of transferring employees 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 grandfathered health plan.

(ii) *Conclusion*. In this *Example 3*, the plan has a bona fide employment-based reason to transfer employees from Option H to Option I. Therefore, 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 the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into section 9815 and ERISA section 715) do not apply to grandfathered health plan coverage. Accordingly, the provisions of PHS Act sections 2701, 2702, 2703, 2705, 2706, 2707, 2709 (relating to coverage for individuals participating in approved clinical trials, as added by section 10103 of the Patient Protection and Affordable Care Act), 2713, 2715A, 2716, 2717, 2719, and 2719A, as added or amended by the Patient Protection and Affordable Care Act, do not apply to grandfathered health plans. (In addition, *see* 45 CFR 147.140(c), which provides that the provisions of PHS Act section 2704, and PHS Act section 2711 insofar as it relates to annual limits, do not apply to grandfathered health plans that are individual health insurance coverage.)

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

(d) *Provisions applicable to all grandfathered health plans*. The provisions of PHS Act section 2711 insofar as it relates to lifetime limits, and the provisions of PHS Act sections 2712, 2714, 2715, and 2718, apply to grandfathered health plans for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2708 apply to grandfathered health plans for plan years beginning on or after January 1, 2014.

(e) *Applicability of PHS Act sections 2704, 2711, and 2714 to grandfathered group health plans and group health insurance coverage*—(1) The provisions of PHS Act section 2704 as it applies with respect to enrollees who are under 19 years of age, and the provisions of PHS Act section 2711 insofar as it relates to annual limits, apply to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2704 apply generally to grandfathered health plans that are 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 child with respect to a grandfathered health plan that is a group health plan only if the adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2)) other than a grandfathered health plan of a parent. For plan years beginning on or after January 1, 2014, the provisions of PHS Act section 2714 apply with respect to a grandfathered health plan that is a group health plan without regard to whether an adult 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 one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010, the coverage is grandfathered health plan coverage at least until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage that amends the coverage solely to conform to any requirement added by subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into section 9815 and ERISA section 715) is not treated as a termination of the collective bargaining agreement. After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the

terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010) and, for any changes in insurance coverage after the termination of the collective bargaining 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 through a group health insurance policy from Issuer W on March 23, 2010. The collective bargaining agreement has not been amended and will not expire before December 31, 2011. The group health plan enters into a new group health insurance policy with Issuer Y for the plan year starting on January 1, 2011.

(ii) *Conclusion*. In this *Example 1*, the group health plan, and the group health insurance policy provided by Y, remains a grandfathered health plan with respect to existing employees and new employees and their families because the coverage is maintained pursuant to a collective bargaining 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 agreement effective January 1, 2012, with the only changes since March 23, 2010 being changes that do not cause the plan to cease to be a grandfathered health plan 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 section. Moreover, the group health insurance policy provided by Y remains a grandfathered health plan under the rules of this section, including paragraph (g) of this section.

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

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

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

(iii) *Increase in a fixed-amount cost-sharing requirement other than a copayment.* Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requirement measured from 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 the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total increase in the copayment measured from 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 medical inflation, plus $5), or

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

(v) *Decrease in contribution rate by employers and employee organizations*—(A) *Contribution rate based on cost of coverage*. A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate 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 any class of similarly situated individuals (as described in §54.9802–1(d)) by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.

(B) *Contribution rate based on a formula*. A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(3)(iii)(B) of this section) towards 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 percent below the 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, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance 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, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of 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, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on 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 following changes to the terms of the plan or health insurance coverage, the changes are considered part of the terms of the plan or health insurance coverage on March 23, 2010 even though they were not effective at that time and such changes do not cause a plan or health insurance coverage to cease to be a 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 department; or

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

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

(3) *Definitions*—(i) *Medical inflation defined*. For purposes of this paragraph (g), the term *medical inflation* means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982 — 1984 base of 100. For this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI-U (unadjusted) published by the Department of Labor for March 2010, using the 1982 — 1984 base 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 amount by 387.142.

(ii) *Maximum percentage increase defined*. For purposes of this paragraph (g), the term *maximum percentage increase* means medical inflation (as 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 contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions of section 4980B(f)(4), section 604 of ERISA, and section 2204 of the PHS Act. In the case of a self-insured plan, contributions by an employer or employee organization are equal to the total cost 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, 2010, made 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 surgery. The plan is 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 be a grandfathered health plan.

Example 2. (i) *Facts*. Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health condition, the treatment 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 necessary to treat the 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 specialists. The plan is subsequently amended to increase the copayment requirement to $40. Within the 12-month period before the $40 copayment takes effect, the 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 - 30 = 10; 10 ÷ 30 = 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 - 387.142 = 87.858; 87.858 ÷ 387.142 = 0.2269). The maximum percentage increase permitted is 37.69% (0.2269 = 22.69%; 22.69% + 15% = 37.69%). Because 33.33% does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 4. (i) *Facts*. Same facts as *Example 3*, except the grandfathered health plan subsequently increases the $40 copayment requirement to $45 for a later plan year. Within the 12-month period before the $45 copayment takes effect, the greatest value of the overall medical care component of 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, 2010) to $45, expressed 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 section) from March 2010 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 grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25.27% + 15% = 40.27%), 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 plan to cease to be a 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 providers. The plan is subsequently amended to increase the copayment requirement to $15. Within the 12-month period before the $15 copayment takes effect, the 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 = 0.5; 0.5 = 50%). Medical inflation (as defined in paragraph (g)(3) of this section) from March 2010 is 0.0720 (415.0 - 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum 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). The $5 increase in copayment in this *Example 5* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv)this section, which 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 copayment ($0) for office visits

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 0.0720 (415.0 - 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv)(A) 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 than the amount calculated 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 cease to be a 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 family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces 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 cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

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

(ii) *Conclusion*. In this *Example 8*, because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under 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 that promises B lifetime health coverage upon termination. Prior to termination, B is covered by W's self-insured grandfathered group health plan. B is terminated after March 23, 2010 and W purchases a new health insurance policy providing coverage to B, consistent with the terms of the employment contract.

(ii) *Conclusion*. In this *Example 9*, because no individual is enrolled in the health insurance policy on March 23, 2010, it is not a grandfathered health 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* §54.9815–1251T for 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
* * * * *	

(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 for June 17, 2010, 75 F.R. 34537)

Part III. Administrative, Procedural, and Miscellaneous

Information Reporting Under the Amendments to Section 6041 for Payments to Corporations and Payments of Gross Proceeds and With Respect to Property

Notice 2010–51

PURPOSE

This notice invites public comments regarding guidance to be provided concerning new requirements with respect to the reporting of payments made in the course of the payor's trade or business. The new reporting requirements are in section 6041 of the Internal Revenue Code (the Code), which was amended by section 9006 of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119 (the Act). Very generally, these amendments expand existing information reporting requirements to apply to payments made to corporations and to include certain payments of gross proceeds and with respect to property. The new reporting requirements under these amendments apply to payments made after December 31, 2011.

BACKGROUND

Section 6041 generally requires information returns to be made by every person (payor) engaged in a trade or business who makes payments, as defined in section 6041(a), aggregating $600 or more in any taxable year to another person (payee) in the course of the payor's trade or business. The information returns must be filed with the Internal Revenue Service and corresponding statements must be sent to each payee. Form 1099–MISC, *Miscellaneous Income,* is generally used for this purpose, although Form W–2, *Wage and Tax Statement*, is generally used for payments to employees. *See* Treas. Reg. §1.6041–1(a)(2).

The Act amended section 6041(a) to add payments of "amounts in consideration for property" and "gross proceeds" to the list of payments subject to reporting. However, the Act retained existing exceptions in section 6041(a) for "payments to which section 6042(a)(1), 6044(a)(1), 6047(e), 6049(a), or 6050N(a) applies," and "payments with respect to which a statement is required under the authority of section 6042(a)(2), 6044(a)(2), or 6045." These excepted payments include most interest, dividends, royalties, and securities and broker transactions.

The Act also added new section 6041(h) regarding the application of section 6041 to payments made to corporations. Existing regulations under section 6041 generally except payments to corporations, exempt organizations, governmental entities, international organizations, and retirement plans from reporting under section 6041. *See* Treas. Reg. §1.6041–3(p). New section 6041(h) provides that, notwithstanding any regulation prescribed by the Secretary before the date of enactment, for purposes of section 6041, the term "person" includes any corporation that is not an organization exempt from tax under section 501(a). Thus, under new section 6041(h), payments to corporations that are not tax-exempt may be subject to information reporting.

Finally, the Act added new section 6041(i) authorizing the Secretary to prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of section 6041, including rules to prevent duplicative reporting of transactions. Also, section 6041(a) provides generally that information returns under section 6041 shall be furnished under such regulations and in such form and manner, and to such extent, as may be prescribed by the Secretary.

REQUEST FOR PUBLIC COMMENTS

The Treasury Department and the Internal Revenue Service intend to issue guidance that will implement these changes to section 6041 in a manner that minimizes burden and avoids duplicative reporting. This notice requests comments regarding possible approaches to the section 6041 guidance that will assist in achieving those goals.

For example, the Treasury Department and the Internal Revenue Service have already issued a proposed regulation that would allow a broad exception from section 6041 information reporting for payment card transactions that would otherwise be reportable under section 6050W of the Code, effective for payments beginning in 2011. This proposed regulation is expected to be finalized later this summer. Thus, business purchases made with payment cards will be exempt from information reporting under section 6041.

The Treasury Department and the Internal Revenue Service request comments on additional circumstances in which duplicative reporting might otherwise occur under section 6041 and another Code section, such as section 3402(t), and on rules that would prevent such duplicative reporting. Specific comments are also requested regarding the burden associated with implementing the new reporting requirements for different types of taxpayers and businesses.

Additional issues on which comments are requested include:

1. The appropriate scope of the terms "gross proceeds" and "amounts in consideration for property" in section 6041(a), as amended, and how to interpret these terms in a manner that minimizes the reporting burden and avoids duplicative reporting.

2. Whether or how the expanded reporting requirements should apply to payments between affiliated corporations, such as payments related to intercompany transactions within the same consolidated group.

3. The appropriate time and manner of reporting to the Service, and what, if any, changes to existing practices for Form 1099 information reporting to the Service are needed to minimize burden in compliance with the new reporting requirements.

4. What, if any, changes to Form W–9, *Request for Taxpayer Identification Number and Certification*, and the existing rules for soliciting taxpayer identification numbers (TINs) are needed to minimize the burden for payors to obtain TINs from payees, what are the privacy concerns with respect to TINs, and what are other concerns regarding identifying payees.

5. How should the backup withholding requirements for missing TINs under the expanded new reporting requirements be administered in order to minimize burden on payors.

Interested parties are invited to submit comments on this notice by

September 29, 2010. Written comments should be submitted to: Internal Revenue Service, CC:PA:LPD:PR (Notice 2010–51), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Alternatively, comments may be hand delivered between the hours of 8:00 a.m. and 4:00 p.m. Monday to Friday to CC:PA:LPD:PR (Notice 2010–51), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, D.C. Comments may also be transmitted electronically via the following e-mail address: *Notice.Comments@irscounsel.treas.gov*. Please include "Notice 2010–51" in the subject line of any electronic communications. All comments will be available for public inspection and copying.

The principal author of this notice is Keith Brau of the Office of Associate Chief Counsel (Procedure & Administration). For further information regarding this notice, please contact Keith Brau at (202) 622–4940 (not a toll-free call).

Part IV. Items of General Interest

Notice of Proposed Rulemaking by Cross-Reference to Temporary Regulations

Group Health Plans and Health Insurance Coverage Rules Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act

REG–118412–10

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: Elsewhere in this issue of the Bulletin, the IRS is issuing temporary regulations (T.D. 9489) under the provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act) dealing with rules relating to status as a grandfathered health plan. The IRS is issuing the temporary regulations at the same time that the Employee Benefits Security Administration of the U.S. Department of Labor and the Office of Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services are issuing substantially similar interim final regulations with respect to group health plans and health insurance coverage offered in connection with a group health plan under the Employee Retirement Income Security Act of 1974 and the Public Health Service Act. The temporary regulations provide guidance to employers, group health plans, and health insurance issuers providing group health insurance coverage. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Written or electronic comments and requests for a public hearing must be received by September 15, 2010.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–118412–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered to: CC:PA:LPD:PR (REG–118412–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224. Alternatively, taxpayers may submit comments electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–118412–10).

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Karen Levin at 202–622–6080; concerning submissions of comments or to request a hearing, Regina Johnson, 202–622–7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)). Comments on the collection of information should be sent to the **Office of Management and Budget**, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the **Internal Revenue Service**, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by August 16, 2010. Comments are specifically requested concerning:

- Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;
- The accuracy of the estimated burdens associated with the proposed collection of information (see the preamble to the temporary regulations published elsewhere in this issue of the Bulletin);
- How to enhance the quality, utility, and clarity of the information to be collected;
- How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and
- Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

The collections of information are in §54.9815–1251T(a)(2) and (a)(3) (see the temporary regulations published elsewhere in this issue of the Bulletin). The temporary regulations require any group health plan or group health insurance coverage intended to be a grandfathered health plan to include in any description of plan benefits provided to participants or beneficiaries a statement that the plan or issuer believes the plan or health insurance coverage is a grandfathered health plan under section 1251 of the Affordable Care Act. The temporary regulations provide model language for this purpose. The temporary regulations also require any such plan or issuer to maintain records documenting the terms of the plan or health insurance coverage on March 23, 2010 and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. The likely respondents to the collections of information requirements are business or other for-profit institutions, and nonprofit institutions. Responses to this collection of information are mandatory if a plan or health insurance coverage is intended to be a grandfathered health plan under the Affordable Care Act.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

The temporary regulations published elsewhere in this issue of the Bulletin add §54.9815–1251T to the Miscellaneous Excise Tax Regulations. The proposed and temporary regulations are being published as part of a joint rulemaking with the Department of Labor and the Department of Health and Human Services (the joint rulemaking). The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the temporary regulations and these proposed regulations.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this proposed regulation. It is hereby certified that the collections of information contained in this notice of proposed rulemaking will not have a significant impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis is not required.

The temporary regulations require any group health plan or group health insurance coverage intended to be a grandfathered health plan to include in any description of plan benefits provided to participants or beneficiaries a statement that the plan or issuer believes the plan or health insurance coverage is a grandfathered health plan under section 1251 of the Affordable Care Act. The temporary regulations provide model language for this purpose. This disclosure requirement applies only when the plan or issuer is otherwise distributing a description of plan benefits. For group health plans maintained by small entities, it is anticipated that the health insurance issuer will prepare the description of plan benefits in almost all cases. Thus, there will almost always be no burden of statement preparation imposed on small business entities. Because the distribution is not required other than when a description of plan benefits is otherwise provided, the distribution requirement will not add any burden to plans maintained by small business entities. For this reason, the information collection requirement of providing a statement, in descriptions of plan benefits, that the plan is intended to be a grandfathered health plan will not impose a significant impact on a substantial number of small entities.

The temporary regulations also require any plan or issuer intending the group health plan or health insurance coverage to be a grandfathered health plan to maintain records documenting the terms of the plan or health insurance coverage on March 23, 2010 and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. Under the temporary regulations, if a sponsor of a group health plan switches to an insurance policy under which none of its employees was covered on March 23, 2010, the plan ceases to be a grandfathered health plan. Thus, an insured plan can maintain its status as a grandfathered health plan only by renewing its contract with the same health insurance issuer. Almost all plans maintained by small business entities are insured plans, and the issuer is also required to satisfy this recordkeeping requirement for the health insurance coverage to remain a grandfathered health plan. It is anticipated that the issuer will satisfy this recordkeeping obligation for almost all small businesses. For this reason, this information collection requirement will not impose a significant impact on a substantial number of small entities.

For further information and for analyses relating to the joint rulemaking, see the preamble to the joint rulemaking. Pursuant to section 7805(f) of the Internal Revenue Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. Comments are specifically requested on the clarity of the proposed regulations and how they may be made easier to understand. All comments will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by a person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Karen Levin, Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), IRS. The proposed regulations, as well as the temporary regulations, have been developed in coordination with personnel from the U.S. Department of Labor and the U.S. Department of Health and Human Services.

* * * * *

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding an entry in numerical order to read as follows:

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

Section 54.9815–1251 also issued under 26 U.S.C. 9833. * * *

Par. 2. Section 54.9815–1251 is added to read as follows:

§54.9815–1251 Preservation of right to maintain existing coverage.

[The text of proposed §54.9815–1251 is the same as the text of §54.9815–1251T published elsewhere in this issue of the Bulletin].

Steven T. Miller,
Deputy Commissioner for Services and Enforcement.

(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 for June 17, 2010, 75 F.R. 34571)

Deletions From Cumulative List of Organizations Contributions to Which are Deductible Under Section 170 of the Code

Announcement 2010–45

The Internal Revenue Service has revoked its determination that the organizations listed below qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Internal Revenue Code of 1986.

Generally, the Service will not disallow deductions for contributions made to a listed organization on or before the date of announcement in the Internal Revenue Bulletin that an organization no longer qualifies. However, the Service is not precluded from disallowing a deduction for any contributions made after an organization ceases to qualify under section 170(c)(2) if the organization has not timely filed a suit for declaratory judgment under section 7428 and if the contributor (1) had knowledge of the revocation of the ruling or determination letter, (2) was aware that such revocation was imminent, or (3) was in part responsible for or was aware of the activities or omissions of the organization that brought about this revocation.

If on the other hand a suit for declaratory judgment has been timely filed, contributions from individuals and organizations described in section 170(c)(2) that are otherwise allowable will continue to be deductible. Protection under section 7428(c) would begin on July 12, and would end on the date the court first determines that the organization is not described in section 170(c)(2) as more particularly set forth in section 7428(c)(1). For individual contributors, the maximum deduction protected is $1,000, with a husband and wife treated as one contributor. This benefit is not extended to any individual, in whole or in part, for the acts or omissions of the organization that were the basis for revocation.

Baby Boomers and Beyond, Inc.
Denham Springs, LA

Children's Angelcare Aid International, Inc.
San Diego, CA

Institute for Unpopular Culture
San Francisco, CA

Jolene's Horse Rescue
Palmdale, CA

Military Order of the Cootie of the US
Tent # 20,
Wellston, OK

Rochester Hills Dance & Arts Society
Rochester Hills, MI

City Club
Dallas, TX

Four a Foundation an Integrated Auxiliary of First Baptist Church
Garland, TX

Georgian Community Services Program, Inc.
Morrow, GA

TARU Gardens, Inc
Charlottesville, VA

UTAH Citizens Alliance
Salt Lake City, UT

Notice of Disposition of Declaratory Judgment Proceedings under Section 7428

Announcement 2010–46

This announcement serves notice to donors that on February 5, 2009, the United States Tax Court entered a stipulated decision that effective December 20, 2000, the organization listed below is not recognized as an organization described in section 501(c)(3), is not exempt from tax under section 501(a), and is not eligible to receive deductible charitable contributions as an organization described in section 170(c)(2).

Douglas and Valerie Wood Charitable Supporting Organization
Latrobe, PA

DPA Alliance Corporation
Provo, UT

After Bankruptcy Foundation, Inc.
Fishers, IN

America's Faith Centered Education, Inc.
Sandy, UT

Airport Working Group of Orange County
Newport Beach, CA

Bear Soldier Industries
Bismarck, ND

Chadwell-Townsend Private Foundation
Bellbrook, OH

Golden Age Benefits Society
Westlake Village, CA

Jordan Ministries, Inc.
Dover, FL

Newton Family Foundation
West Jordan, UT

United American Housing & Education Foundation
Houston, TX

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D. —Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z —Corporation.

Numerical Finding List[1]

Bulletins 2010–27 through 2010–29

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[1] A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2010–1 through 2010–26 is in Internal Revenue Bulletin 2010–26, dated June 28, 2010.

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[1] A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2010–1 through 2010–26 is in Internal Revenue Bulletin 2010–26, dated June 28, 2010.

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