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Internal Revenue Service

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DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AB89

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 147

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Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document includes final rules regarding grandfathered group health plans and grandfathered group health insurance coverage that amend current rules to provide greater flexibility for certain grandfathered health plans to make changes to certain types of fixed- amount cost-sharing requirements without causing a loss of grandfather status under the Patient Protection and Affordable Care Act.

DATES:

Effective Date: These regulations are effective January 14, 2021.

Applicability Date: These regulations are applicable June 15, 2021.

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Customer Service Information:

Individuals interested in obtaining information from the Department of Labor (DOL) concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the DOL's website (*www.dol.gov/ebsa*). In addition, information from the Department of Health and Human Services (HHS) regarding private health insurance coverage and non-federal governmental group health plans can be found on the Centers for Medicare & Medicaid Services (CMS) website (*www.cms.gov/cciio*), and information on healthcare reform can be found at *www.HealthCare.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. Purpose

On January 20, 2017, the President issued Executive Order 13765, ''Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal'' (82 FR 8351) ''to minimize the unwarranted economic and regulatory burdens of the [Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively, PPACA), as amended].'' To meet these objectives, the President directed that the executive departments and agencies with authorities and responsibilities under PPACA, ''to the maximum extent permitted by law . . . shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of [PPACA] that would impose a fiscal burden on any state or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications.''

HHS, DOL, and the Department of the Treasury (collectively, the Departments) share interpretive jurisdiction over section 1251 of PPACA, which generally provides that certain group health plans and health insurance coverage existing as of March 23, 2010, the date of enactment of PPACA (referred to collectively in the statute as grandfathered health plans), are subject to only certain provisions of PPACA. Consistent with the objectives of Executive Order 13765, on February 25, 2019, the Departments issued a request for information regarding grandfathered group health plans and grandfathered group health insurance coverage (2019 RFI).[1] The purpose of the 2019 RFI was to gather input from the public in order to better understand the challenges that group health plans and group health insurance issuers face in avoiding a loss of grandfather status, and to determine whether there are opportunities for the Departments to assist such plans and issuers, consistent with the law, in preserving the grandfather status of group health plans and group health insurance coverage in ways that would benefit plan participants and beneficiaries, employers, employee organizations, and other stakeholders.

Based on feedback received from stakeholders who submitted comments in response to the 2019 RFI, the Departments issued a notice of proposed rulemaking on July 15, 2020 (referred to as the 2020 proposed rules), that would, if finalized, amend current rules to provide greater flexibility for certain grandfathered health plans to make changes to certain types of cost-sharing requirements without causing a loss of grandfather status.[2] After careful consideration of the comments received, the Departments are issuing final rules that adopt the proposed amendments without substantive change. In the Departments' view, these amendments are appropriate because they will enable these plans to continue offering affordable coverage while also enhancing their ability to respond to rising healthcare costs. In some cases, the amendments would also ensure that the plans are able to comply with minimum cost-sharing requirements for high deductible health plans (HDHPs) so enrolled individuals are eligible to contribute to health savings accounts (HSAs).

The final rules only address the requirements for grandfathered group health plans and grandfathered group health insurance coverage and do not apply to or otherwise change the current requirements applicable to grandfathered individual health insurance coverage. With respect to individual health insurance coverage, it is the Departments' understanding that the number of individuals with grandfathered individual health

[1] 84 FR 5969 (Feb. 25, 2019).

[2] 85 FR 42782 (July 15, 2020)

insurance coverage has declined each year since PPACA was enacted. As one comment received in response to the 2019 RFI noted, this decline in enrollment in grandfathered individual health insurance coverage will continue due to natural churn, because most consumers stay in the individual market for less than 5 years.[3] Moreover, compared to the number of individuals in grandfathered group health plans and grandfathered group health insurance coverage, only a small number of individuals are enrolled in grandfathered individual health insurance coverage. [4] The Departments are therefore of the view that any amendments to requirements for grandfathered individual health insurance coverage would be of limited utility.

B. Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage

Section 1251 of PPACA provides that grandfathered health plans are not subject to certain provisions of PPACA for as long as they maintain their status as grandfathered health plans.[5] For example, grandfathered health plans are subject neither to the requirement to cover certain preventive services without cost sharing under section 2713 of the Public Health Service Act (PHS Act), enacted by section 1001 of PPACA, nor to the annual limitation on cost sharing set forth under section 1302(c) of PPACA and section 2707(b) of the PHS Act, enacted by section 1201 of PPACA. If a plan were to lose its grandfather status, it would be required to comply with both provisions, in addition to several other requirements.

On June 17, 2010, the Departments issued interim final rules with request for comments implementing section 1251 of PPACA.[6] On November 17, 2010, the Departments issued an amendment to the interim final rules with request for comments to permit certain changes in policies, certificates, or contracts of insurance without a loss of grandfather status.[7] Also, over the course of 2010 and 2011, the Departments released Affordable Care Act Implementation Frequently Asked Questions (FAQs) Parts I, II, IV, V, and VI to answer questions related to maintaining a plan's status as a grandfathered health plan.[8] After consideration of comments and feedback received from stakeholders, the Departments issued regulations on November 18, 2015, which finalized the interim final rules without substantial change and incorporated the clarifications that the Departments had previously provided in other guidance (2015 final rules).[9]

In general, under the 2015 final rules, a group health plan or group health insurance coverage is considered grandfathered if it was in existence, and has continuously provided coverage for someone (not necessarily the same person, but at all times at least one person) since March 23, 2010, provided the plan (or its sponsor) or issuer has not taken certain actions resulting in the plan relinquishing grandfather status.

Under the 2015 final rules, certain changes to a group health plan or coverage do not result in a loss of grandfather status. For example, new employees and their families may enroll in a group health plan or group health insurance coverage without causing a loss of grandfather status. Further, the addition of a new contributing employer or a new group of employees of an existing contributing employer to a grandfathered multiemployer health plan will not affect the plan's grandfather status. Also, grandfather status is determined separately for each benefit package option available under a group health plan or coverage; thus, if any benefit package under the plan or coverage loses its grandfather status, it will not affect the grandfather status of the other benefit packages, provided that any other changes do not exceed the other standards that cause a plan to relinquish grandfather status, as explained further in this preamble.

The 2015 final rules specify the circumstances under which changes to the terms of a plan or coverage cause the plan or coverage to cease to be a grandfathered health plan. Specifically, the regulations outline certain changes to benefits, cost-sharing requirements, and contribution rates that will cause a plan or coverage to relinquish its grandfather status. There are six types of changes (measured from March 23, 2010) that will cause a group health plan or health insurance coverage to cease to be grandfathered:

1. The elimination of all or substantially all benefits to diagnose or treat a particular condition;

2. Any increase in a percentage cost-sharing requirement (such as coinsurance);

3. Any increase in a fixed-amount cost-sharing requirement (other than a copayment) (such as a deductible or out-of-pocket maximum) that exceeds certain thresholds;

4. Any increase in a fixed-amount copayment that exceeds certain thresholds;

5. A decrease in contribution rate by an employer or employee organization toward the cost of coverage of any tier of coverage for any class of similarly situated individuals by more than five percentage points below the rate for the coverage period that includes March 23, 2010; or

6. The imposition of annual limits on the dollar value of all benefits for group health plans and insurance coverage that did not impose such a limit prior to March 23, 2010.

The 2015 final rules provide different thresholds for the increases to different types of cost-sharing requirements that will cause a loss of grandfather status. The nominal dollar amount of a coinsurance obligation automatically rises when the cost of the healthcare benefit subject to the coinsurance obligation increases, so changes to the

[3] The cause of this churn varies. For example, beginning a new job that offers group health coverage may result in a transition from the individual market to group coverage. Eligibility for Medicaid or Medicare can also result in a consumer leaving the individual market.

[4] HHS estimates that less than seven percent of enrollees in grandfathered plans have individual market coverage. This estimate is based on analysis of enrollment data issuers submitted in the HHS Health Insurance and Oversight System (HIOS) and the CMS External Data Gathering Environment (EDGE) for the 2018 plan year, as well as Kaiser Family Foundation estimates regarding the percentage of enrollees with employer-sponsored coverage that are covered by a grandfathered health plan.

[5] For a list of the market reform provisions applicable to grandfathered health plans under title XXVII of the PHS Act that PPACA added or amended and that were incorporated into the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (the Code), visit *https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/grandfathered-health-plans-provisions-summary-chart.pdf.*

[6] 75 FR 34538 (June 17, 2010).

[7] 75 FR 70114 (Nov. 17, 2010).

[8] *See* Affordable Care Act Implementation FAQs Part I, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-i.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html;* Affordable Care Act Implementation FAQs Part II, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-ii.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html;* Affordable Care Act Implementation FAQs Part IV, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-iv.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html;* Affordable Care Act Implementation FAQs Part V, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-v.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html;* and Affordable Care Act Implementation FAQs Part VI, available at *https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-vi.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html.*

[9] 80 FR 72192 (Nov. 18, 2015), codified at 26 CFR 54.9815–1251, 29 CFR 2590.715–1251, and 45 CFR 147.140.

level of coinsurance (such as modifying a requirement that the patient pay 20 percent to a requirement that the patient pay 30 percent of inpatient surgery costs) can significantly alter the balance of financial obligations between participants and beneficiaries and a plan or health insurance coverage. On the other hand, fixed-amount cost-sharing requirements (such as copayments and deductibles) do not automatically rise when healthcare costs increase. This means that changes to fixed-amount cost-sharing requirements (for example, modifying a $35 copayment to a $40 copayment for outpatient doctor visits) may be reasonable to keep pace with the rising cost of medical items and services. Accordingly, under the 2015 final rules, 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, however, there are two standards for permitted increases, one for fixed-amount cost-sharing requirements other than copayments (for example, deductibles and out-of-pocket maximums) and another for copayments.

With respect to fixed-amount cost-sharing requirements other than copayments, a plan or coverage ceases to be a grandfathered health plan if there is an increase, since March 23, 2010, that is greater than the maximum percentage increase. The 2015 final rules define the maximum percentage increase as medical inflation (from March 23, 2010) plus 15 percentage points. For this purpose, medical inflation is defined by reference to the overall medical care component of the Consumer Price Index for All Urban Consumers, unadjusted (CPI–U), published by the DOL using the 1982–1984 base of 100.

For fixed-amount copayments, a plan or 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 (1) the maximum percentage increase (calculated in the same manner as for fixed amount cost-sharing requirements other than copayments) or (2) five dollars (as increased by medical inflation).

For any change that causes a loss of grandfather status under the 2015 final rules, the plan or coverage will cease to be a grandfathered plan when the change becomes effective, regardless of when the change is adopted.

In addition, the 2015 final rules require that a grandfathered plan or coverage both include a statement in any summary of benefits provided under the plan that it believes the plan or coverage is a grandfathered health plan and provide contact information for questions and complaints. Failure to provide this disclosure results in a loss of grandfather status. The 2015 final rules further provide that, once grandfather status is relinquished, there is no opportunity to regain it.

C. 2019 Request for Information

It is the Departments' understanding that the number of grandfathered group health plans and grandfathered group health insurance policies has declined each year since the enactment of PPACA, but many employers continue to maintain grandfathered group health plans and coverage. That a significant number of grandfathered group health plans and coverage remain indicates that some employers and issuers have found value in preserving grandfather status. Accordingly, on February 25, 2019, the Departments published the 2019 RFI to gather input from the public in order to better understand the challenges that group health plans and group health insurance issuers face in avoiding the loss of grandfather status and to determine whether there are opportunities for the Departments to assist such plans and issuers, consistent with the law, in preserving the grandfather status of group health plans and group health insurance coverage in ways that would benefit plan participants and beneficiaries, employers, employee organizations, and other stakeholders.

Comments submitted in response to the 2019 RFI provided information regarding grandfathered health plans that helped inform the 2020 proposed rules. Commenters shared data regarding the prevalence of grandfathered group health plans and grandfathered group health insurance coverage, insights regarding the impact that grandfathered plans have had in terms of delivering benefits to participants and beneficiaries at a lower cost than non-grandfathered plans, and suggestions for potential amendments to the Departments' 2015 final rules that would provide more flexibility for a plan or coverage to retain grandfather status.

Several commenters directed the Departments' attention to a Kaiser Family Foundation survey, which indicates that one out of every five firms that offered health benefits in 2018 offered at least one grandfathered health plan, and 16 percent of covered workers were enrolled in a grandfathered group health plan that year.[10] One commenter indicated the incidence of grandfathered plan status differs by various types of plan sponsors. Another commenter cited survey data released in 2018 by the International Foundation of Employee Benefit Plans, which indicated that 57 percent of multiemployer plans are grandfathered, compared to 20 percent of other private-sector plans and 30 percent of public-sector plans. However, a professional association with members who work with employer groups on health plan design and administration commented that their members have found far fewer grandfathered plans than survey results suggest exist and suggested that very large employers with self-funded plans may sponsor a disproportionate share of grandfathered plans, as well as that some employers that have ''grandmothered'' plans or that previously had grandfathered plans may unintentionally be reporting incorrectly in surveys that they still sponsor grandfathered plans. [11]

Some commenters stated that grandfathered health plans are less comprehensive and provide fewer consumer protections than non-grandfathered plans; thus, these commenters opined that the Departments should not amend the 2015 final rules to provide greater flexibility for a plan or coverage to maintain grandfather status. Other commenters noted, however, that grandfathered

[10] *See* 2018 *Employer Health Benefits Survey,* Kaiser Family Foundation, available at *https://www.kff.org/report-section/2018-employer-healthbenefits-survey-section-13-grandfathered-healthplans.* On October 8, 2020, the Kaiser Family Foundation issued its 2020 report. According to survey data, 16 percent of offering firms report having at least one grandfathered plan in 2020, and 14 percent of covered workers were enrolled in a grandfathered health plan in 2020. *See 2020 Employer Health Benefits Survey,* Kaiser Family Foundation, available at *http://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf.*

[11] ''Grandmothered'' plans, also known as transitional plans, are certain non-grandfathered health insurance coverage in the small group and individual market that meet certain conditions. On November 14, 2013, CMS issued a letter to the State Insurance Commissioners outlining a policy under which, if permitted by the state, non-grandfathered small group and individual market health plans that were in effect on October 1, 2013, could continue and would not be treated as being out of compliance with certain specified PPACA market reforms under certain conditions. CMS has extended this non-enforcement policy each subsequent year, with the most recent extension in effect until policy years beginning on or before October 1, 2021, provided that all such coverage comes into compliance by January 1, 2022. *See Insurance Standards Bulletin Series—INFORMATION—Extension of Limited Non-Enforcement Policy through 2021* (January 31, 2020), available at *https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2021.pdf.*

plans often have lower premiums and cost-sharing requirements than non-grandfathered plans. One commenter gave examples of premium increases ranging from 10 percent to 40 percent that grandfathered plan participants would experience if they transitioned to non-grandfathered group health plans. Several commenters also stated that grandfathered health plans do in fact offer comprehensive benefits and in some cases are even more generous than certain non-grandfathered plans that are subject to all the requirements of PPACA. Some commenters also stated that their grandfathered plans offer more robust provider networks than other coverage options that are available to them or that access to a grandfathered plan ensures that they are able to keep receiving care from current in-network providers.

Commenters who supported allowing greater flexibility for grandfathered health plans offered a range of suggestions regarding how the Departments should amend the 2015 final rules. For example, several commenters requested additional flexibility regarding plan or coverage changes that would constitute an elimination of substantially all benefits to diagnose or treat a condition, stating that it is often difficult to discern what constitutes a benefit reduction given that the regulations apply a ''facts and circumstances'' standard. Some commenters requested flexibility to make certain changes so long as the grandfathered plan or coverage's actuarial value is not affected. Some commenters also stated that the 2015 final rules should be amended to permit decreases in contribution rates by employers and employee organizations by more than five percentage points to account for employers experiencing a business change or economic downturn.

Commenters also suggested amendments relating to the permitted changes in cost-sharing requirements for grandfathered plans. These commenters generally argued that the 2015 final rules were too restrictive. Several commenters stated that relying on the medical care component of the CPI–U for purposes of those rules to account for inflation adjustments to the maximum percentage increase was misguided, and the methodology used to calculate the ''premium adjustment percentage'' (as defined in 45 CFR 156.130) would be more appropriate because it is tied to the increase in premiums for health insurance and, therefore, better reflects the increase in costs for health coverage. These commenters also noted that relying on the premium adjustment percentage would be consistent with the methodology used to adjust the annual limitation on cost sharing under section 1302(c) of PPACA and section 2707(b) of the PHS Act that applies to non-grandfathered plans. Additionally, one commenter articulated a concern that the 2015 final rules eventually may preclude some grandfathered group health plans or issuers of grandfathered group health insurance coverage from being able to make changes to cost-sharing requirements that are necessary for a plan to maintain its status as an HDHP within the meaning of section 223 of the Code, which would effectively mean that individuals covered by those plans would no longer be eligible to contribute to an HSA.

D. The Premium Adjustment Percentage

Section 1302(c)(4) of PPACA directs the Secretary of HHS to determine an annual premium adjustment percentage, a measure of premium growth that is used to set the rate of increase for three parameters detailed in PPACA: (1) The maximum annual limitation on cost sharing (defined at 45 CFR 156.130(a)); (2) the required contribution percentage used to determine eligibility for certain exemptions under section 5000A of the Code (defined at 45 CFR 155.605(d)(2)); and (3) the employer shared responsibility payment amounts under section 4980H(a) and (b) of the Code (see section 4980H(c)(5) of the Code). Section 1302(c)(4) of PPACA and 45 CFR 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013, and 45 CFR 156.130(e) provides that this percentage will be published annually by HHS.

To calculate the premium adjustment percentage for a benefit year, HHS calculates the percentage by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds the average per capita premium for health insurance for 2013 and rounds the resulting percentage to 10 significant digits. The resulting premium index reflects cumulative, historic growth in premiums from 2013 through the preceding year. HHS calculates the premium adjustment percentage using as a premium growth measure the most recently available National Health Expenditure Accounts (NHEA) projection of per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) at the time of publication of the premium adjustment percentage.[12]

E. High Deductible Health Plans and HSA-compatibility

Section 223 of the Code permits eligible individuals to establish and contribute to HSAs. HSAs are tax-favored accounts established for the purpose of accumulating funds to pay for qualified medical expenses on behalf of the account beneficiary, his or her spouse, and any claimed dependents. In order for an individual to qualify as an eligible individual under section 223(c)(1) of the Code (and thus to be eligible to make tax-favored contributions to an HSA) the individual must be covered under an HDHP. An HDHP is a health plan that satisfies certain requirements with respect to minimum deductibles and maximum out-of-pocket expenses, which increase annually with cost-of-living adjustments. Generally, except for preventive care, an HDHP may not provide benefits for any year until the deductible for that year is met. Pursuant to section 223(g) of the Code, the minimum deductible for an HDHP is adjusted annually for cost of living based on changes in the Chained Consumer Price Index for All Urban Consumers (C–CPI–U).[13]

F. 2020 Proposed Rules

On July 15, 2020, the Departments issued the 2020 proposed rules that would, if finalized, amend the 2015 final rules to provide greater flexibility for grandfathered group health plans and issuers of grandfathered group health insurance coverage to make certain changes without causing a loss of grandfather status. However, there is no authority for non-grandfathered plans to become grandfathered. Therefore, the 2020 proposed rules did not provide any opportunity for a plan or coverage that has lost its grandfather status under the 2015 final rules to regain that status.

[12] 85 FR 29164, 29228 (May 14, 2020). The series used in the determinations of the adjustment percentages can be found in Table 17 on the CMS website, which can be accessed by clicking the ''NHE Projections 2018–2027—Tables'' link located in the Downloads section at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.* A detailed description of the NHE projection methodology is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf.*

[13] The Tax Cuts and Jobs Act, Public Law 115–97, 131 Stat. 2054 (Dec. 22, 2017), amended section 1(f)(3) of the Code to use the C–CPI–U rather than CPI–U for certain inflation adjustments for tax years beginning after December 31, 2017.

In issuing the 2020 proposed rules, the Departments considered comments submitted in response to the 2019 RFI regarding ways that the 2015 final rules could be amended. The Departments did not include in the 2020 proposed rules many suggestions outlined in those comments because, in the Departments' view, those suggestions would have allowed for such significant changes that the modified plan or coverage could not reasonably be described as being the same plan or coverage that existed on March 23, 2010, for purposes of grandfather status. The Departments were persuaded, however, by commenters' statements that there are better means of accounting for inflation in the standard for the maximum percentage increase that should be permitted to fixed-amount cost-sharing requirements. The Departments also agreed that, as one commenter on the 2019 RFI highlighted, there is an opportunity to specify that changes to fixed-amount cost-sharing requirements that are necessary for a plan to maintain its status as an HDHP should not cause a loss of grandfather status. Given that the 2015 final rules permit increases that are meant to account for inflation in healthcare costs over time, the Departments were of the view that those suggestions were reasonably narrow and consistent with the intent of the 2015 final rules to permit adjustments in response to inflation without causing a loss of grandfather status.

Accordingly, the Departments proposed to amend the 2015 final rules in two ways. First, the 2020 proposed rules included a new paragraph (g)(3), which specified that grandfathered group health plans and grandfathered group health insurance coverage that are HDHPs may make changes to fixed-amount cost-sharing requirements that would otherwise cause a loss of grandfather status without causing a loss of grandfather status, but only to the extent those changes are necessary to comply with the requirements for HDHPs under section 223(c)(2)(A) of the Code. Second, the 2020 proposed rules included a revised definition of ''maximum percentage increase'' at redesignated paragraph (g)(4), which provided an alternative method of determining that amount based on the premium adjustment percentage. Under the 2020 proposed rules, this alternative method would be available only for grandfathered group health plans and grandfathered group health insurance coverage with changes that are effective on or after the applicability date of a final rule.

The Departments requested comments on all aspects of the 2020 proposed rules, as well as on specific issues related to the 2020 proposed rules where stakeholder feedback would be particularly useful in evaluating whether to issue final rules, and what the content of any final rules should be.

The comment period for the 2020 proposed rules closed on August 14, 2020. The Departments received 13 comments. After careful consideration of these comments, for the reasons explained further in the preamble, the Departments are issuing the final rules, which finalize the 2020 proposed rules without substantive change.

II. Overview of the Final Rules

A. General Response to Public Comments on the 2020 Proposed Rules

Some commenters expressed support for the 2020 proposed rules because the 2020 proposed rules would allow grandfathered group health plans and issuers offering grandfathered group health insurance coverage to make certain key changes without causing a loss of grandfather status. One commenter noted that providing more flexibility to maintain grandfather status should help both plan sponsors and participants. This commenter highlighted that plan sponsors could continue to avoid the costs and burdens associated with compliance with the additional requirements applicable to non-grandfathered plans while plan participants and beneficiaries could retain their current coverage instead of finding alternate coverage and potentially experiencing greater increases in cost sharing or reductions in benefits.

The final rules will allow grandfathered group health plan sponsors and issuers of grandfathered group health insurance coverage more flexibility to make changes to certain types of cost-sharing requirements without causing a loss of grandfather status. The Departments view this flexibility as a way to enable plan sponsors and issuers to continue to offer quality, affordable coverage to their participants and beneficiaries while appropriately taking into account rising healthcare costs. The Departments also are of the view that providing this flexibility will help participants and beneficiaries in grandfathered group health plans maintain their current coverage, including their provider and service network(s). Further, the final rules will provide participants and beneficiaries with the ability to maintain access to affordable coverage options offered by their employers or unions by ensuring that employers and other plan sponsors have the ability to more appropriately account for the rising costs of healthcare due to inflation.

Several commenters did not support the 2020 proposed rules and urged the Departments not to finalize them. These commenters generally stated that finalizing the 2020 proposed rules would allow employers to continue to offer plans that do not provide comprehensive benefits while placing an increased financial burden on participants and beneficiaries. The commenters also noted that grandfathered group health plans lack certain essential patient protections, and that the consequences of not having complete information about grandfathered coverage will be especially detrimental for patients with complex medical conditions. These commenters further asserted that ensuring access to robust coverage and benefits such as preventive services and maternity care is especially important and that, in light of the ongoing COVID–19 pandemic, now is not an appropriate time to allow changes that could shift more costs to consumers.

While the Departments appreciate these concerns, the Departments are of the view that finalizing the 2020 proposed rules strikes a proper balance between preserving plans', issuers', participants', and beneficiaries' ability to maintain existing coverage with the goals of expanding access to and improving the quality of health coverage. The Departments are also of the view that the final rules appropriately support the goal of promoting greater choice in coverage, especially in light of rising healthcare costs. While grandfathered health plans are not required to comply with all PPACA market reform provisions, there are many PPACA consumer protections that are applicable to all group health plans and issuers offering group health insurance coverage, regardless of grandfather status, including the prohibition on preexisting condition exclusions, the prohibition on waiting periods that exceed 90 days, the prohibition on lifetime or annual dollar limits, the prohibition on rescissions, and the requirement for plans and issuers that offer dependent coverage of children to do so up to age 26. Further, grandfathered group health plans and issuers of grandfathered group health insurance coverage are not prohibited from providing coverage consistent with any of the PPACA market provisions that apply to non-grandfathered group health plans and may add that coverage without relinquishing grandfather

status, provided these changes are made without exceeding the standards established by paragraph (g)(1) of the grandfather regulations.

Several commenters urged the Departments to not finalize the 2020 proposed rules due to the ongoing coronavirus disease of 2019 (COVID–19) pandemic. These commenters highlighted that the COVID–19 pandemic has created high levels of economic uncertainty for millions of Americans while also posing risks to their health and safety. The commenters voiced concern that the 2020 proposed rules could have a harmful impact on access to care and affordability during the ongoing COVID–19 pandemic.

As evidenced by the Administration's efforts to address the COVID–19 pandemic, the Departments appreciate that the COVID–19 pandemic has created a greater need for affordable healthcare options for consumers and, accordingly, have taken a number of actions to provide relief and promote increased access to benefits during the COVID–19 pandemic.[14] For example, the Departments have published regulatory and subregulatory guidance to assist individuals during the COVID–19 pandemic, including those who have lost their health coverage, and have extended a number of deadlines so that participants and beneficiaries in employee benefit plans have additional time to make critical health coverage decisions affecting their benefits during the COVID–19 pandemic.[15] The Departments highlight that the final rules provide flexibility to employers that currently offer health coverage and have consistently done so since 2010, with the aim that their employees will have a greater ability to maintain that coverage, should they so choose. Accordingly, the Departments are of the view that the flexibility afforded by the final rules is unlikely to exacerbate any difficulties employees may experience in obtaining access to care during the COVID–19 pandemic and will potentially enable employers and employees to maintain more affordable coverage than they may otherwise be able to maintain. Notwithstanding these considerations, the Departments are delaying the applicability of the final rules, to be applicable 6 months after publication in the **Federal Register**, as discussed later in this preamble.

One commenter raised concerns that the continued availability of grandfathered plans might contribute to segmentation of the small-group market, causing adverse selection and, in turn, higher premiums for small businesses that offer or want to offer plans subject to the PPACA market reforms. This commenter noted that, because the non-grandfathered small-group market is subject to modified community rating and a ''single risk pool,'' firms with younger or healthier-than-average employees have incentives to opt out of the small group market single risk pool, at the expense of other firms that may therefore face higher premiums. Commenters also claimed that the Departments do not have sufficient information and data to accurately predict the financial effect that the 2020 proposed rules would have on consumers.

The Departments acknowledge that the existence of grandfathered group health plans potentially creates market segmentation and adverse selection in the small group market. However, the Departments do not anticipate that the additional flexibilities provided in the final rules will materially increase market segmentation, or adverse selection, as the final rules do not provide a mechanism for non-grandfathered plans to become grandfathered. For this reason, the Departments are of the view that the changes allowed by the final rules will not have a measurable impact on premiums for small businesses that offer or want to offer non-grandfathered group health insurance coverage. Moreover, the Departments do not expect the number of plans that maintain grandfather status because of the final rules to be so significant as to exacerbate any market segmentation that may already exist.

The Departments also received comments stating that consumers risk being confused or having difficulty with the term ''grandfathered.'' One commenter noted it may be difficult to know whether grandfathered plan participants and beneficiaries are actively choosing to remain in such plans, whether they typically have other non-grandfathered options that they could select, whether they even know a plan is grandfathered, or whether they understand which PPACA consumer protections might be missing when they enroll in grandfathered coverage. Other commenters suggested the addition of greater transparency requirements for employers that offer grandfathered plans as a means to avoid confusion.

The Departments note that these concerns relate to grandfathered plans generally and are not specific to the limited changes made in the proposed or final rules. Under the 2015 final rules, to maintain status as a grandfathered plan, a group health plan or health insurance coverage must include a statement in any summary of benefits that the plan or coverage believes it is a grandfathered plan. It

[14] The Departments continue to work with employers and individuals to help them understand the new laws and regulatory relief and to benefit from them, as intended. On April 11, 2020, the Departments issued FAQs Part 42 regarding implementation of the Families First Coronavirus Response Act (FFCRA), and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and other health coverage issues related to COVID–19 available at: *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf.* In this guidance, the Departments strongly encourage all group health plans and health insurance issuers to promote the use of telehealth and other remote care services. The Departments' guidance also provides enforcement relief that allows plans and issuer to make changes to increase telehealth benefits more quickly than is possible under current law. Specifically, the Departments will not enforce regulations that generally require plans and issuers to provide 60 days' advance notice of certain changes to plan terms and prohibit issuers from making mid-year modifications to health insurance products, with respect to any change that adds benefits or reduces or eliminates cost-sharing requirements for telehealth services and other remote care services. On June 23, 2020, the Departments issued a second round of FAQs, Part 43, providing further guidance regarding requirements of the FFCRA and the CARES Act and related issues available at: *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf.* In light of the critical need to minimize the risk of exposure to and community spread of COVID–19, the FAQs provide a statement of temporary enforcement relief regarding certain requirements that would otherwise apply in order to allow large employers to offer stand-alone telehealth benefits to employees who are not eligible for the employer's primary group health plan. Furthermore, the Departments of Labor and the Treasury published a Joint Notice—Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries (85 FR 26351) on May 4, 2020, *https://www.govinfo.gov/content/pkg/FR-2020-05-04/pdf/2020-09399.pdf.* The Joint Notice extends timeframes for requesting special enrollment in a group health plan, the COBRA election period, and COBRA premium due dates, and certain timeframes relating to benefit claims appeals. On May 14, 2020, HHS published guidance that announced that HHS concurred with the relief specified in the Joint Notice and would adopt a temporary policy of relaxed enforcement to extend similar timeframes otherwise applicable to non-Federal governmental group health plans and health insurance issuers offering coverage in connection with a group health plan, and their participants and beneficiaries, under applicable provisions of title XXVII of the PHS Act, available at *https://www.cms.gov/files/document/Temporary-Relaxed-Enforcement-Of-Group-Market-Timeframes.pdf.*

[15] *See e.g.,* Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak, 85 FR 26351 (May 4, 2020); FAQs About First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42 (April 11, 2020) available at *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf* and *https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf;* FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43 (June 23, 2020), available at *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf* and *https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf.*

must also provide contact information for questions and complaints. The 2015 final rules provide model language that the plan or coverage can use to satisfy the disclosure requirement. That language specifically highlights that grandfathered plans are subject to some, but not all, of the PPACA consumer protections that apply to non-grandfathered plans, such as not being subject to the requirement to provide certain preventive health services without cost sharing. This required disclosure of grandfather status is intended to alleviate confusion consumers may face regarding the term ''grandfathered'' and what benefits and protections are offered under such coverage. The disclosure language is model language, and plans and issuers may include additional disclosure elements, such as the entire list of market reform provisions that do not apply to the specific grandfathered health plan.

Moreover, group health plans, including grandfathered plans, are subject to a number of disclosure requirements under which participants and beneficiaries are entitled to comprehensive information about their benefits. For example, group health plans that are subject to ERISA are required to distribute a summary plan description (SPD) to participants and beneficiaries that provides a comprehensive description of the benefits offered by the plan.[16] In addition, group health plans and issuers of group health insurance coverage, including grandfathered plans, are required to provide a summary of benefits and coverage (SBC) that provides information about benefits and cost sharing in connection with enrollment and renewal.[17] Furthermore, typically, if a plan or issuer makes a material modification to any term that affects the content of the SBC and that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, notice of the change must be provided no later than 60 days prior to the date the modification is effective.[18]

The Departments have concluded that existing disclosure requirements are sufficient to ensure that participants and beneficiaries have access to relevant information, including information regarding cost sharing, to help them understand the implications of grandfathered coverage. The information included in the model grandfather notice—in particular the language highlighting that certain consumer protections under PPACA do not apply to grandfathered coverage, alongside the information available to individuals in their plan's SPD and SBC—provides ample disclosure to participants and beneficiaries regarding their benefits to help them decide whether to enroll or remain in such a plan. Therefore, the Departments are declining to include any additional disclosure requirements in the final rules.

a. Special Rule for Certain Grandfathered HDHPs

As explained above, paragraph (g)(1) of the 2015 final rules identifies certain types of changes that will cause a plan or coverage to cease to be a grandfathered health plan, including increases in cost-sharing requirements that exceed certain thresholds. However, cost-sharing requirements for a grandfathered group health plan or group health insurance coverage that is an HDHP must satisfy the minimum annual deductible requirement and maximum out-of-pocket expenses requirement under section 223(c)(2)(A) of the Code in order to remain an HDHP. The Internal Revenue Service updates these amounts annually to reflect a cost-of-living adjustment.

The annual cost-of-living adjustment to the required minimum deductible for an HDHP has not yet exceeded the maximum percentage increase that would cause an HDHP to lose grandfather status.[19] Nevertheless, the Departments are of the view that there is value in specifying that if a grandfathered group health plan or group health insurance coverage that is an HDHP increases its fixed-amount cost-sharing requirements to meet a future adjusted minimum annual deductible requirement under section 223(c)(2)(A) of the Code that is greater than the increase that would be permitted under paragraph (g)(1) of the 2015 final rules, such an increase would not cause the plan or coverage to relinquish its grandfather status. Otherwise, if such a conflict were to occur, the plan sponsor or issuer would have to decide whether to preserve the plan's grandfather status or its status as an HDHP, potentially causing participants and beneficiaries to experience either substantial changes to their coverage (and likely premium increases) or a loss of eligibility to contribute to an HSA.

To address this potential conflict, the 2020 proposed rules included a new paragraph (g)(3), which provided that, with respect to a grandfathered group health plan or group health insurance coverage that is an HDHP, increases to fixed-amount cost-sharing requirements that otherwise would cause a loss of grandfather status would not cause the plan or coverage to relinquish its grandfather status, but only to the extent the increases are necessary to maintain its status as an HDHP under section 223(c)(2)(A) of the Code.[20] Thus, increases with respect to such a plan or coverage that would otherwise cause a loss of grandfather status and that exceed the amount necessary to satisfy the minimum annual deductible requirement under section 223(c)(2)(A) of the Code would still cause a loss of grandfather status. The 2020 proposed rules also added a new example 11 under paragraph (g)(5) to illustrate how this special rule would apply.

Several commenters supported the 2020 proposed rules to allow a grandfathered HDHP to make changes to fixed-amount cost-sharing requirements without causing a loss of grandfather status to the extent the increases are necessary to maintain the plan's status as an HDHP. One commenter highlighted that without this regulatory change, HDHPs could be forced out of their grandfather status if the annual cost-of-living adjustment to the required minimum deductible for an HDHP exceeds the maximum percentage increase allowed under the 2015 final rules. Another commenter articulated that without this provision, participants and beneficiaries who are covered under a grandfathered HDHP and eligible to contribute to an HSA may lose their eligibility to contribute to an HSA if their plan chooses to relinquish its HDHP status to maintain its grandfather

[16] ERISA Section 102.

[17] 26 CFR 54.9815–2715, 29 CFR 2590.715–2715, 45 CFR 147.200.

[18] 26 CFR 54.9815–2715(b), 29 CFR 2590.715–2715(b), 45 CFR 147.200(b).

[19] For calendar year 2020, a ''high deductible health plan'' is defined under Code section 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) for which do not exceed $6,900 for self-only coverage or $13,800 for family coverage. Rev. Proc. 2019–25 (2019–22 I.R.B. 1261). For calendar year 2021, a ''high deductible health plan'' is defined under Code section 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) for which do not exceed $7,000 for self-only coverage or $14,000 for family coverage. Rev. Proc. 2020–32 (2020–24 I.R.B. 930).

[20] Paragraph (g)(3) of the 2015 final rules would be renumbered as paragraph (g)(4), and subsequent paragraphs would be renumbered accordingly. Additionally, the 2020 proposed rules included conforming amendments to other paragraphs to update all cross-references to those subparagraphs.

status. The commenter also raised the concern of facing substantial premium increases as a result of having to choose other health coverage in the event of an HDHP failing to maintain its HDHP status.

The Departments agree that the special rule for grandfathered HDHPs could help participants and beneficiaries enrolled in these plans. The Departments are of the view that there is value in specifying that grandfathered HDHPs will not be forced to choose whether to preserve their grandfather status or their status as an HDHP and that they can continue to provide the coverage with which their participants and beneficiaries are familiar and comfortable. The Departments also agree that this special rule will help ensure that plans are able to comply with minimum cost-sharing requirements for HDHPs so participants and beneficiaries covered under HDHPs can continue to be eligible to contribute to HSAs. In adopting the final rules, the Departments specifically intend to ensure that participants and beneficiaries enrolled in HDHPs with grandfather status are able to maintain their eligibility to contribute to HSAs.

Other commenters expressed concerns that allowing grandfathered HDHPs to preserve both their grandfather status and HDHP status by implementing fixed dollar cost-sharing increases that exceed the standards established under the 2015 final rules might result in increased costs for consumers enrolled in HDHPs. These commenters stated that the proposed changes would further exacerbate existing affordability issues, in particular by raising deductibles to potentially unaffordable levels and subjecting consumers to increased cost sharing. Several commenters noted that increased cost sharing for HDHPs may discourage consumers from seeking medical care or cause consumers to forego treatment if the necessary services became unaffordable. Moreover, commenters noted that high out-of-pocket costs for medical care related to the diagnosis and/or treatment of COVID–19 may deter individuals from seeking care, potentially contributing to increased transmission of COVID–19.

The Departments acknowledge commenters' concerns related to potential increased cost and affordability issues, but the Departments do not anticipate significant cost increases for consumers enrolled in grandfathered HDHPs. In addition, this special rule is narrowly tailored, as it permits flexibility only to the extent necessary to maintain a plan's status as an HDHP under section 223(c)(2)(A) of the Code. Without this regulatory change, grandfathered HDHPs could be forced to choose between maintaining grandfather status and remaining HDHPs. The flexibility offered by the special rule for grandfathered HDHPs will benefit participants and beneficiaries covered under these plans as it balances potential affordability issues with safeguards. Specifically, the final rules allow plan sponsors to continue offering grandfathered coverage, thereby enabling participants and beneficiaries to maintain existing coverage, while only permitting plan sponsors to make certain cost-sharing increases to the extent necessary to maintain HDHP status. Moreover, the Departments expect that the impact of the special rule will be modest: Sponsors of grandfathered HDHPs will have greater flexibility to continue offering their plans as grandfathered, protecting those enrolled in these plans from the disruption and potentially increased out-of-pocket costs associated with changing to a different plan or coverage that may not be an HDHP or grandfathered. This consideration carries particular weight because of the COVID–19 pandemic, during which losing access to a plan or coverage, potentially including losing access to a specific provider network, could be particularly disruptive.

b. Definition of Maximum Percentage Increase

Under the 2015 final rules, medical inflation means the increase since March 2010 in the overall medical care component of the CPI–U published by the DOL using the 1982–1984 base of 100. The medical care component of the CPI–U is a measure of the average change over time in the prices paid by urban consumers for medical care. Although the Departments continue to be of the view that this is an appropriate measure for medical inflation in this context, the Departments recognize that the medical care component of CPI–U reflects not only changes in price for private insurance, but also for self-pay patients and Medicare, neither of which are reflected in the underlying costs for grandfathered group health plans and grandfathered group health insurance coverage. In contrast, the premium adjustment percentage reflects the cumulative, historic growth from 2013 through the preceding calendar year in premiums for only private health insurance, excluding Medigap and property and casualty insurance. Therefore, the Departments agreed with comments received in response to the 2019 RFI that the premium adjustment percentage may better reflect the increase in underlying costs for grandfathered group health plans and grandfathered group health insurance coverage.[21]

Accordingly, the 2020 proposed rules included an amended definition of the maximum percentage increase with an alternative standard that relies on the premium adjustment percentage, rather than medical inflation (which continues to be defined, for purposes of these rules, as the overall medical care component of the CPI–U, unadjusted), to account for changes in healthcare costs over time. Under the 2020 proposed rules, this alternative standard would not supplant the current standard; rather, it would be available to the extent it yields a higher-dollar value than the current standard, and it would apply only with respect to increases in fixed-amount cost-sharing requirements that are made effective on or after the applicability date of the final rules. With respect to increases for group health plans and group health insurance coverage made effective on or after March 23, 2010, but before the applicability date of the final rules, the maximum percentage increase would still be defined as medical inflation expressed as a percentage, plus 15 percentage points.[22]

Thus, under the 2020 proposed rules, increases to fixed-amount cost-sharing requirements for grandfathered group health plans and grandfathered group health insurance coverage that are made applicable on or after the applicability date of the final rules would cause the plan or coverage to cease to be a grandfathered health plan if the total percentage increase in the cost-sharing requirement measured from March 23,

[21] The Departments acknowledge that the premium adjustment percentage does not capture premium growth from 2010 to 2013, and that it reflects increases in premiums not only in the group market, but also in the individual market, which have increased more rapidly than premiums for group health plans and group health insurance. However, the Departments have concluded that the premium adjustment percentage may be the best alternative existing measure to reflect the increase in underlying costs for grandfathered group health plans and grandfathered group health insurance coverage. Additionally, the Departments are of the view that using a measure with which plans and issuers are already familiar will promote administrative simplicity.

[22] The amendments included in the 2020 proposed rules would apply only with respect to grandfathered group health plans and grandfathered group health insurance coverage. Because HHS regulations at 45 CFR 147.140 apply to both grandfathered individual and group health coverage, the amended definition of the maximum percentage increase in the HHS proposed rules would also add a separate provision for individual health insurance coverage to make clear that the definition applicable to individual coverage remains unchanged.

2010 exceeds the greater of (1) medical inflation, expressed as a percentage, plus 15 percentage points; or (2) the portion of the premium adjustment percentage, as defined in 45 CFR 156.130(e), that reflects the relative change between 2013 and the calendar year prior to the effective date of the increase (that is, the premium adjustment percentage minus 1), expressed as a percentage, plus 15 percentage points.[23] The 2020 proposed rules also added a new example 5 under paragraph (g)(5) to demonstrate how this alternative measure for determining the maximum percentage increase might apply in practice. Similar to other examples in paragraph (g)(5), the proposed new example 5 included hypothetical numbers with respect to both the overall medical care component of the CPI–U and the premium adjustment percentage that do not relate to any specific time period and are used for illustrative purposes only. The 2020 proposed rules also renumbered examples 5 through 9 in paragraph (g)(5) to allow the inclusion of new example 5 and revised examples 3 through 6 to clarify that these examples involve plan changes that became effective before the applicability date of these final rules. These proposed revisions would ensure that the examples accurately reflect the other provisions of the 2015 final rules.

In support of this provision in the 2020 proposed rules, one commenter pointed out that the ability to use a premium adjustment percentage for permitted changes in fixed cost-sharing amounts would be helpful to multiemployer plan sponsors wishing to maintain grandfather status. Another commenter said that the premium adjustment percentage is an amount very familiar to group health plan sponsors, and it is based on factors related to group plan premiums, making it a natural complement to the grandfathered plan cost-sharing requirements.

Some commenters stated that the 2020 proposed rules should have provided even greater flexibility. One commenter suggested that instead of examining changes to healthcare costs over cumulative years since March 23, 2010, the Departments should consider allowing a set percentage of allowable increase annually. Another commenter urged the Departments to make additional changes in the final rules to provide more flexibility, allowing plan design changes specifically to encourage cost-effective quality care, such as greater ability to change cost sharing for brand drugs and out-of-network benefits.

One commenter stated that the Departments' intent to allow grandfathered plans to increase out-of-pocket costs at a rate that is the greater of the medical inflation adjustment or the premium adjustment percentage adjustment (plus 15 percentage points) would, by design, result in increased out-of-pocket costs for participants and beneficiaries. This commenter stated that using the premium adjustment percentage for this calculation would leave patients vulnerable to financial hardship. Another commenter asserted that the proposed amendment to the definition of maximum percentage increase would likely result in increased cost sharing, and in turn, less favorable coverage for individuals enrolled in grandfathered coverage, to the detriment of many consumers who rely on employment-based health coverage and who may not have an option to enroll in coverage that complies with the generally applicable market reforms made by PPACA.

As stated earlier in this preamble, the Departments have concluded that the proposed and final rules strike the right balance between allowing grandfathered health plans the flexibility to design their health plans to meet their changing needs and ensuring that affordable healthcare options for participants and beneficiaries remain available. The Departments are unpersuaded that the final rules will result in significant financial hardship due to the additional permitted increases in out-of-pocket costs for participants and beneficiaries. As noted earlier in this preamble, providing an alternative inflation adjustment for fixed-amount cost-sharing increases will help plans and issuers better account for changes in the costs of health coverage over time, potentially allowing them to maintain the grandfathered coverage for those participants and beneficiaries. Therefore, the Departments are of the view that allowing plans and issuers to use this measure is appropriate and it may capture changes in healthcare costs at least as accurately as the medical inflation standard. Accordingly, the Departments are finalizing this change, as proposed.

III. Effective Date

In the 2020 proposed rules, the Departments proposed an effective date of 30 days after publication of the final rules. The Departments are finalizing as proposed an effective date of 30 days after publication of the final rules, which would be January 14, 2021. However, in response to comments, the Departments are including an applicability date which will make the final rules applicable to grandfathered group health plans and grandfathered group health insurance coverage beginning on June 15, 2021. While the Departments did not receive any comments specifically requesting that the applicability date of the final rules be delayed to 6 months after publication, the Departments did receive a number of comments related to the COVID–19 pandemic and the timing of the final rules, as discussed earlier in this preamble. Commenters expressed concern that it is not appropriate to potentially place a greater financial burden related to healthcare on patients while the COVID–19 pandemic is ongoing.

As explained above, in the Departments' view, the final rules will allow employers to continue to offer affordable coverage to those who are eligible for grandfathered employer-sponsored plans. However, the Departments acknowledge commenters' reasonable concerns regarding the timing of the final rules and the uncertainty created by the COVID–19 pandemic. The Departments are therefore delaying the applicability date of the final rules to 6 months after publication in the **Federal Register**. The Departments are of the view that this delay is appropriate, as the Departments do not expect the delay to have a significant short-term impact on plans' and issuers' ability to make use of the cost-sharing flexibilities afforded under the final rules; instead, a short delay will reduce uncertainty by allowing plans, issuers, and those covered by grandfathered plans more time to understand and plan for the increased flexibility provided by the final rules.

IV. Economic Impact Analysis and Paperwork Burden

A. Summary/Statement of Need

Section 1251 of PPACA generally provides that certain group health plans and health insurance coverage existing on March 23, 2010, are not subject to certain provisions of PPACA as long as they maintain grandfather status. On February 25, 2019, the Departments published an RFI to gather information on grandfathered group health plans and grandfathered group health insurance coverage. Comments received from stakeholders in response to the 2019 RFI suggested that issuers and plan sponsors, as well as participants and

[23] Stakeholders should look to official publications from the Bureau of Labor Statistics and HHS to identify the relevant overall medical care component of the CPI–U amount or premium adjustment percentage with respect to a change being considered by a grandfathered health plan.

beneficiaries, continue to value grandfathered group health plan and grandfathered group health insurance coverage. The Departments issued a notice of proposed rulemaking on July 15, 2020, to amend the 2015 final rules to provide greater flexibility for certain grandfathered health plans to make changes to certain types of cost-sharing requirements without causing a loss of grandfather status. The Departments are of the view that these final rules are appropriate to provide certain grandfathered health plans greater flexibility while appropriately taking into account rising healthcare costs. Additionally, the final rules will ensure that grandfathered plans are able to make changes to comply with minimum cost-sharing requirements for HDHPs without losing grandfather status, so enrolled individuals continue to be eligible to contribute to HSAs. These changes will allow certain grandfathered group health plans and grandfathered group health insurance coverage to continue to be exempt from certain provisions of PPACA and allow those plans' participants and beneficiaries to maintain their current coverage.

In drafting the final rules, the Departments attempted to balance a number of competing interests. The Departments sought to balance providing greater flexibility to grandfathered group health plans and grandfathered group health insurance coverage that will enable these plans and coverage to continue offering quality, affordable coverage to participants and beneficiaries while ensuring that the final rules will not allow for such significant changes that the plan or coverage could not reasonably be described as being the same plan or coverage that was offered on March 23, 2010. Additionally, the Departments sought to allow grandfathered group health plans and grandfathered group health insurance coverage to better account for rising healthcare costs, including ensuring that grandfathered group HDHPs are able to maintain their grandfather status, while continuing to comply with minimum cost-sharing requirements for HDHPs, so that the individuals enrolled in the HDHPs are eligible to contribute to an HSA. In previous rulemaking, the Departments recognized that many group health plans 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 requirements change, and covered items and services may vary. Without some flexibility to make adjustments while retaining grandfather status, the ability of many individuals to maintain their current coverage would be frustrated, because much of the grandfathered group health plan coverage would quickly cease to be regarded as the same health plan or health insurance coverage in existence on March 23, 2010. At the same time, allowing grandfathered health plans and grandfathered group health insurance coverage to make unfettered changes while retaining grandfather status would be inconsistent with Congress's intent in enacting PPACA.[24]

The final rules amend the 2015 final rules to provide greater flexibility for grandfathered group health plans and issuers of grandfathered group health insurance coverage in two ways. First, the final rules specify that any grandfathered group health plan and grandfathered group health insurance coverage that is an HDHP may make changes to fixed-amount cost-sharing requirements that would otherwise cause a loss of grandfather status without causing a loss of grandfather status, but only to the extent those changes are necessary to comply with the requirements for HDHPs under section 223(c)(2)(A) of the Code. Second, the final rules include a revised definition of maximum percentage increase, which provides an alternative standard that relies on the premium adjustment percentage, rather than medical inflation, to account for changes in healthcare costs over time, providing for an alternative inflation adjustment for fixed-amount cost-sharing increases.

B. Overall Impact

The Departments have examined the impacts of the final rules as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act (SSA), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year).

Section 3(f) of Executive Order 12866 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 1 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.

An RIA must be prepared for major rules with economically significant effects ($100 million or more in any one year), and a ''significant'' regulatory action is subject to Office of Management and Budget (OMB) review. The final rules are not likely to have economic impacts of $100 million or more in any 1 year, and therefore do not meet the definition of ''economically significant'' within the meaning of section 3(f)(1) of Executive Order 12866. However, OMB has determined that the actions are significant within the meaning of section 3(f)(4) of the Executive Order. Therefore, OMB has reviewed the final rules, and the Departments have provided the following assessment of their impact.

Some commenters stated that the rules should not be finalized because the Departments had insufficient information and data to estimate the effects of the 2020 proposed rules on grandfathered group health plans and coverage as well as those enrolled in such coverage. The Departments acknowledge that, given the lack of information and data, the Departments are not able to precisely estimate the

[24] 75 FR 34538, 34546 (June 17, 2010).

overall impact of the final rules. As discussed later in the impact analysis, the Departments note the inability to predict what changes each grandfathered group health plan will make in response to the final rules. The Departments recognize that some grandfathered group health plans may take advantage of flexibilities provided by the final rules to change certain types of cost-sharing requirements in amounts greater than the current rules allow, potentially increasing out-of-pocket costs at a higher rate for some participants and beneficiaries, while potentially reducing premiums for others. However, other grandfathered group health plans may make relatively minor, or no, changes. As discussed previously in this preamble, the Departments note that the fact that a significant number of grandfathered group health plans and coverage remain indicates that some employers and issuers have found value in preserving grandfather status. The Departments are of the view that preserving grandfather status will enable participants to retain their current coverage, including their provider network(s), maintain access to affordable coverage options, and ensure that employers and other grandfathered group health plan sponsors can more appropriately account for the rising costs of healthcare due to inflation. The Departments have also concluded that the final rules appropriately support the goal of promoting greater choices in coverage, especially in light of rising healthcare costs.

C. Impact Estimates of Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage Provisions and Accounting Table

The final rules amend the 2015 final rules to provide greater flexibility for grandfathered group health plan sponsors and issuers of grandfathered group health insurance coverage to make certain changes to cost-sharing requirements without causing a loss of grandfather status. The final rules specify that issuers or sponsors of any grandfathered group health plan and grandfathered group health insurance coverage that is an HDHP may make changes to fixed-amount cost-sharing requirements that would otherwise cause a loss of grandfather status without causing a loss of grandfather status, but only to the extent those changes are necessary to comply with the requirements for HDHPs under section 223(c)(2)(A) of the Code. The final rules also revise the definition of maximum percentage increase to provide an alternative standard that relies on the premium adjustment percentage, rather than medical inflation, to account for changes in healthcare costs over time. In accordance with OMB Circular A–4, Table 1 depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action.

The Departments are unable to quantify all benefits, costs, and transfers of the final rules. The effects in Table 1 reflect non-quantified impacts and estimated direct monetary costs and transfers resulting from the provisions of the final rules for grandfathered group health plans, issuers of grandfathered group health coverage, participants, and beneficiaries.

TABLE 1—ACCOUNTING TABLE

Benefits

Non-Quantified:

- Increases flexibility for plan sponsors and issuers of grandfathered group health plans and grandfathered group health insurance coverage to make changes to certain fixed-amount cost-sharing requirements without losing grandfather status.
- If there is uptake of this flexibility:
  - Allows participants and beneficiaries in grandfathered group health plans and grandfathered group health insurance coverage to maintain coverage they are familiar with and potentially provides continuity of care by not requiring them to change their health plan to one that may not include their current provider(s).
  - Ensures plan sponsors are able to comply with minimum cost-sharing requirements for HDHPs and allows participants and beneficiaries to maintain their coverage and eligibility to contribute to an HSA.
- Decreases the likelihood that plan sponsors would cease offering health benefits due to a lack of flexibility to make changes to certain fixed cost-sharing amounts without losing grandfather status.
- Potential reduction in adverse health outcomes if there is a decrease in the uninsured rate if participants and beneficiaries choose to obtain coverage due to potential premium reductions for grandfathered group health plans and grandfathered group health insurance coverage and seek needed healthcare.

Costs:	Primary estimate (million)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized ($/year)	$6.09	2020	7	2021–2025
	$5.67	2020	3	2021–2025

Quantitative:

- Regulatory review costs of $26.73 million, incurred in 2021, by grandfathered group health plan coverage sponsors and issuers.

Non-Quantified:

- Potential increase in adverse health outcomes if a participant or beneficiary foregoes treatment because the necessary services became unaffordable due to an increase in cost-sharing.
- Potential increase in adverse health outcomes if there is an increase in the uninsured rate if participants and beneficiaries choose to cancel their coverage or decline to enroll because of the increases in cost-sharing requirements associated with grandfathered group health plans and grandfathered group health insurance coverage.
- If an employer would have otherwise switched to a non-grandfathered plan, potential increase in adverse health outcomes if a participant or beneficiary foregoes treatment for medical conditions that are not covered by their grandfathered group health plan and grandfathered group health insurance coverage, but that would have been covered by non-grandfathered health plan coverage subject to all PPACA market reforms.

Transfers

Non-Quantified:

- For grandfathered group health plans and grandfathered group health insurance coverage that utilize the expanded flexibilities to increase fixed-amount cost-sharing requirements, potential transfers occur from participants and beneficiaries with resulting higher out-of-pocket costs to participants and beneficiaries with no or low out-of-pocket costs and nonparticipants through potentially lower premiums and correspondingly smaller wage adjustments to pay for the premiums.
- If an employer would have otherwise switched to a non-grandfathered plan with expanded benefits, potential transfers occur from participants and beneficiaries who would have benefited from these expanded benefits to others in the plan who would not have benefited from these expanded benefits through lower premiums and correspondingly smaller wage adjustments.

Table 1 provides the anticipated benefits, costs, and transfers (quantitative and non-quantified) to sponsors and issuers of grandfathered health plan coverage, participants and beneficiaries enrolled in grandfathered plans, as well as nonparticipants. The following section describes the benefits, costs, and transfers to grandfathered group health plan sponsors, issuers of grandfathered group health insurance coverage, and those individuals enrolled in such plans.

Economic Impacts of Retaining or Relinquishing Grandfather Status and Affected Entities and Individuals

The Departments estimate that there are 2.5 million ERISA-covered plans offered by private employers that cover an estimated 136.2 million participants and beneficiaries in those private employer-sponsored plans.[25] Similarly, the Departments estimate that there are 84,087 state and local governments that offer health coverage to their employees, with an estimated 32.8 million participants and beneficiaries in those employer-sponsored plans.[26]

The Kaiser Family Foundation 2020 Employer Health Benefits Survey reports that 16 percent of firms offering health benefits have at least one health plan or benefit package option that is a grandfathered plan, and 14 percent of covered workers are enrolled in grandfathered plans.[27] Using this information, the Departments estimate that, of those firms offering health benefits, 400,000 sponsor ERISA-covered plans (2.5 million * 0.16) that are grandfathered (or include a grandfathered benefit package option) and cover 19.1 million participants and beneficiaries (136.2 million * 0.14). The Departments further estimate there are 13,454 state and local governments (84,087 * 0.16) offering at least one grandfathered health plan and 4.6 million participants and beneficiaries (32.8 million * 0.14) covered by a grandfathered state or local government plan.

Although the Kaiser Family Foundation 2020 Employer Health Benefits Survey reports that 20 percent of firms offering health benefits offered an HDHP and 24 percent of covered workers were enrolled in HDHPs, the Departments are of the view that the 2010 Employer Health Benefits Survey provides a better estimate of the prevalence of HDHPs in the grandfathered group market as it provides an estimate for the number of potential HDHPs that would have been able to obtain and maintain grandfather status. The 2010 Employer Health Benefits Survey reported that 12 percent of firms offering health benefits offered an HDHP, and 6 percent of covered workers were enrolled in HDHPs.[28]

Benefits

The Departments are of the view that the economic effects of the final rules will ultimately depend on decisions made by grandfathered plan sponsors (including sponsors of grandfathered HDHPs) and the preferences of plan participants and beneficiaries. To determine the value of retaining a health plan's grandfather status, each group plan sponsor must determine whether the plan, under the rules applicable to grandfathered health plan coverage, will continue to be more or less favorable than the plan as it would exist under the rules applicable to non-grandfathered group health plans. This determination will depend on such factors as the respective prices of grandfathered group health plan and non-grandfathered group health plans, the willingness of grandfathered group health plans' covered populations to pay for benefits and protections available under non-grandfathered group health plans, and the participants' and beneficiaries' willingness to accept any increases in out-of-pocket costs due to changes to certain types of cost-sharing requirements. The Departments have concluded that providing flexibilities to make changes to certain types of cost-sharing requirements in grandfathered group health plans and grandfathered group health insurance coverage without causing a loss of grandfather status will enable plan sponsors and issuers to continue to offer quality, affordable coverage to their participants and beneficiaries while taking into account rising healthcare costs.

The Departments anticipate that the premium adjustment percentage index will continue to experience faster growth than medical CPI–U, and therefore are of the view that providing the alternative method of determining the maximum percentage increase will, over time, give grandfathered group health plans and grandfathered group health insurance coverage the flexibility to make changes to the plans' fixed-amount cost-sharing requirements (such as copayments, deductibles, and out-of-pocket limits) that would have previously resulted in the loss of grandfather status. Thus, the Departments are of the view that the final rules will allow sponsors of those grandfathered group health plans and coverage to continue to provide the coverage with which their participants and beneficiaries are familiar and comfortable, without the unnecessary burden of finding other coverage. Additionally, if the flexibilities provided for in the final rules result in a reduction in grandfathered group health plan and grandfathered group health insurance coverage premiums, there could potentially be a reduction in adverse health outcomes if participants and beneficiaries chose to obtain coverage they may have previously foregone and seek needed healthcare.[29]

[25] U.S. Department of Labor, EBSA calculations using the 2019 Medical Expenditure Panel Survey, Insurance Component (MEPS–IC), the Form 5500 and 2017 Census County Business Patterns; Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2019 Annual Social and Economic Supplement to the Current Population Survey, Table 3C *(forthcoming).*

[26] 2017 Census of Governments, Government Organization Report, available at *https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html;* 2017 MEPS–IC State and Local Government data, available for query at *https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC/startup.;* Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2019 Annual Social and Economic Supplement to the Current Population Survey, Table 3C, (forthcoming).

[27] The Departments note that comments received in response to the 2019 RFI and summarized earlier in this preamble described data obtained from Kaiser Family Foundation 2018 Employer Health Benefits Survey. *See supra* note 9. For the purposes of this RIA, the Departments used more recent data from the same survey. *See* Kaiser Family Foundation, ''2020 Employer Health Benefits Survey,'' available at *https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/.*

[28] Kaiser Family Foundation, ''2010 Employer Health Benefits Survey,'' (Sept. 2010), available at: *https://www.kff.org/wp-content/uploads/2013/04/8085.pdf.*

[29] To the extent that utilization and health expenditures are relatively stable, the Departments

As noted previously in this preamble, in response to the 2019 RFI, some commenters suggested that their grandfathered plans offer more robust provider networks than other coverage options available to them or that they want to ensure that participants and beneficiaries are able to keep receiving care from current in-network providers. The Departments are of the view that providing the flexibilities in the final rules will help participants and beneficiaries maintain their current provider and service networks. If providers continue participating in the grandfathered plans' networks, this continuity offers participants and beneficiaries the ability to continue current and future care through those providers with whom they have built relationships.

As discussed previously in this preamble, one commenter on the 2019 RFI articulated a concern that the 2015 final rules may eventually preclude some sponsors and issuers of grandfathered group health plans and grandfathered group health insurance coverage from being able to make changes to fixed-amount cost-sharing requirements necessary to maintain a plan's HDHP status. For participants and beneficiaries, this would mean they could experience either substantial changes to their coverage (and likely premium increases) or a loss of eligibility to contribute to an HSA. The Departments expect that, under the 2015 final rules, there may be limited circumstances in which a grandfathered group health plan or grandfathered group health insurance coverage that is an HDHP (grandfathered HDHP) is unable to simultaneously maintain its grandfather status and satisfy the requirements for HDHPs under section 223(c)(2)(A) of the Code. Nonetheless, to avoid this scenario and provide assurance to grandfathered group health plan sponsors and issuers of grandfathered HDHPs, the final rules allow a grandfathered HDHP to make changes to fixed-amount cost-sharing requirements that otherwise could cause a loss of grandfather status without causing a loss of grandfather status, but only to the extent the increases are necessary to comply with the requirements for HDHPs under section 223(c)(2)(A) of the Code.

The Departments have concluded that providing this flexibility to grandfathered HDHPs will allow them to preserve their grandfather status even if they increase their cost-sharing requirements to meet a future adjusted minimum annual deductible requirement under section 223(c)(2)(A) of the Code beyond the increase that would be permitted under paragraph (g)(1) of the 2015 final rules. Under section 223(g) of the Code, the required minimum deductible for an HDHP is adjusted for cost-of-living based on changes in the overall economy. Historically, the allowed increases under the 2015 final rules, which are based on changes in medical care costs (medical CPI–U), have exceeded increases based on changes in the overall economy (CPI–U or, for tax years beginning after December 31, 2017, C–CPI–U). Using 10 years of projections from the President's FY 2021 Budget, medical-CPI–U is expected to grow faster than CPI–U. Further, because the allowed increases under the 2015 final rules are based on the cumulative effect over a period of years, it is unlikely that using medical-CPI–U to index deductibles would result in lower deductibles than using C–CPI–U as required under section 223(g) of the Code.[30] Therefore, the Departments note that, to the extent these trends continue, it is unlikely that an increase required under section 223 of the Code for a plan to remain an HDHP would exceed the allowed increases under the 2015 final rules. Furthermore, to the extent that the revised definition of maximum percentage increase in the final rules will allow the deductible to grow as fast, or faster, than under the 2015 final rules, grandfathered HDHPs may not need to avail themselves of the additional flexibility provided in the final rules. Nevertheless, the Departments are of the view that affording this flexibility will make the rules more transparent to sponsors of grandfathered HDHPs. Thus, the final regulations will allow participants and beneficiaries enrolled in those plans to maintain their current coverage, continue contributing to any existing HSA, and potentially realize any reduction in premiums that may result from changes in cost-sharing requirements.

Costs and Transfers

The Departments recognize there are costs associated with the final rules that are difficult to quantify given the lack of information and data. For example, the Departments do not have data related to the current annual out-of-pocket costs for participants and beneficiaries in grandfathered group HDHPs or other grandfathered group health plans and grandfathered group health insurance coverage. The Departments recognize that as medical care costs increase, some participants and beneficiaries in grandfathered health plans could face higher out-of-pocket costs for services that may be excluded by such plans, but that would be required to be covered by non-grandfathered group health plans and group health insurance coverage subject to PPACA market reforms. As noted earlier in this analysis, it is possible that lower premiums, compared to the likely premiums if these rules are not finalized, could partially offset these increased costs. Further, participants and beneficiaries who would otherwise be covered by a non-grandfathered plan could potentially face increases in adverse health outcomes if they forego treatment because certain services are not covered by their grandfathered plan or coverage. The Departments cannot precisely predict the number of group health plans and group health insurance coverage that will retain their grandfather status as a result of the final rules. According to the annual Kaiser Family Foundation Employer Health Benefits Survey, the percentage of employers offering health coverage that offered at least one grandfathered plan between 2016 and 2019 has been relatively stable (23 percent in 2016 to 22 percent in 2019).[31] The Departments are of the view that a large change over that time period would have indicated that the 2015 final rules were too

expect that higher cost sharing may lead to lower premiums, both because higher cost sharing will reduce issuers' share of the costs of care and because of medical loss ratio (MLR) requirements, which encourage issuers to pass these savings to consumers in the form of lower premiums.

[30] As noted earlier in this preamble, the Tax Cuts and Jobs Act amended section 1(f)(3) of the Code, cross-referenced in section 223(g) of the Code, to refer to C–CPI–U, instead of CPI–U, for tax years beginning after December 31, 2017.

[31] *See* Kaiser Family Foundation, ''2016 Employer Health Benefits Survey,'' available at *https://www.kff.org/health-costs/report/2016-employer-health-benefits-survey/;* Kaiser Family Foundation, ''2017 Employer Health Benefits Survey,'' available at *https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/;* Kaiser Family Foundation, ''2018 Employer Health Benefits Survey,'' available at *https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/;* and Kaiser Family Foundation, ''2019 Employer Health Benefits Survey,'' available at *https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.* Despite the relative stability between 2016 and 2019, the 2020 Employer Health Benefits Survey reported that the number of firms offering health coverage that offered at least one grandfathered plan in 2020 decreased to 16 percent. The Departments are of the view that this change may largely be attributable to issues with employer survey reporting during the COVID–19 pandemic, rather than to the 2015 final rules. The Kaiser Family Foundation reported a diminished response to the 2020 survey compared to previous years and attributed that lower response rate to a combination of factors including changing data collection firms, disruptions from the COVID–19 pandemic, and starting the fielding period later. Kaiser Family Foundation, ''2020 Employer Health Benefits Survey,'' available at *https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/.*

restrictive and that a relaxation of those rules would have a large effect. The actual small change suggests the opposite. Therefore, the Departments do not expect a significant impact on the number of grandfathered group health plans or grandfathered group health insurance coverage as a result of the final rules.

For those plans and coverages that continue to maintain their grandfather status as a result of the flexibilities in the final rules, the participants and beneficiaries will continue to have coverage and may experience lower premiums when compared to non-grandfathered group health plans. Although some participants and beneficiaries will pay higher cost-sharing amounts, these increased costs may be partially offset by reduced employee premiums, and indirectly through potential wage adjustments that reflect reduced employer contributions due to any resulting lower premiums. In contrast, individuals who have low or no medical expenses, along with nonparticipants, will be unlikely to experience increased cost-sharing amounts and may benefit from lower employee premiums, and indirectly through potential wage adjustments.

The Departments recognize there will be transfers associated with the final rules that are difficult to quantify given the lack of information and data. The Departments realize that if plan sponsors avail themselves of the flexibilities in the final rules, some participants and beneficiaries of grandfathered group health plans and grandfathered group health insurance coverage will potentially see increases in out-of-pocket costs depending on the changes made to their plans. Additionally, participants and beneficiaries in a grandfathered HDHP could face increases in the plan's deductible if plans increase their fixed-amount cost-sharing requirements to meet a future adjusted minimum annual deductible requirement beyond the increase that is permitted under the 2015 final rules. Changes in costs associated with increased deductibles or other cost sharing will be a transfer from participants and beneficiaries with higher out-of-pocket costs to participants and beneficiaries with lower or no out-of-pocket costs and to nonparticipants, as the related premium reductions could affect wages.

Due to the overall lack of information and data related to what grandfathered group plan sponsors will choose to do, the Departments are unable to precisely estimate the overall economic impact, but the Departments anticipate that the overall impact will be minimal. However, there is a large degree of uncertainty regarding the effect of the final rules on any potential changes to cost sharing at the plan level so actual experience could differ.

Commenters suggested that the provisions of the 2020 proposed rules would disadvantage consumers with pre-existing conditions. Specifically, commenters suggested that those individuals most likely to shoulder the burden of increased out-of-pocket costs are those who already have higher medical expenses and out-of-pocket costs (for example, those with blood cancer). Another commenter noted that the 2020 proposed rules suggested that the resulting increases in out-of-pocket expenditures for participants and beneficiaries of grandfathered plans could be offset by decreases in premiums or wage adjustments; however, according to this commenter, those potential benefits are minimal and uncertain, while participants and beneficiaries will likely be paying more for substandard health coverage. Another commenter suggested that the Departments should fully evaluate and publicly report on whether increased cost sharing will lead to decreased utilization of necessary medical care.

The Departments appreciate these concerns. Nevertheless, the Departments are of the view that finalizing the 2020 proposed rules is important to help grandfathered group health plans and grandfathered group health insurance coverage maintain grandfather status and supports the goal of promoting greater choice in coverage, especially in light of rising healthcare costs. The Departments recognize that should a grandfathered group health plan or grandfathered group health insurance coverage avail itself of the flexibilities in the final rules, some participants and beneficiaries could incur higher out-of-pocket costs for ongoing or future healthcare needs. However, as discussed previously in this preamble, participants and beneficiaries would continue to benefit from many PPACA consumer protections that are applicable to all group health plans and group health insurance coverage, regardless of grandfather status, including the prohibition on preexisting condition exclusions, the prohibition on waiting periods that exceed 90 days, and the prohibition on lifetime or annual dollar limits. Additionally, grandfathered group health plans and issuers of grandfathered group health insurance coverage are not prohibited from providing coverage consistent with any of PPACA market provisions that apply to non-grandfathered group health plans and may add coverage consistent with such market provisions without relinquishing grandfather status.

As discussed later in the impact analysis, some participants and beneficiaries could experience savings in reduced premiums, wage adjustments, and continued access to tax-advantaged HSAs due to changes made as a result of the final rules. The Departments recognize that any increases in cost sharing, changes in premiums, or wage adjustments are at the discretion of the issuer or grandfathered group plan sponsor. The Departments are of the view that providing the flexibilities in the final rules could allow participants to retain their current coverage instead of finding alternate coverage, which may result in greater increases in cost-sharing or reduced benefits for those individuals. As noted later in the impact analysis, the Departments are of the view that because individuals with significant healthcare needs generally exceed the out-of-pocket limit for the plan year, they are only modestly affected by increases in cost-sharing requirements, while individuals with fewer healthcare needs are more likely to be affected by an increase in fixed-amount cost-sharing, but that they incur a small portion of the overall costs.

The Departments have concluded that the final rules strike a proper balance between preserving the ability to maintain existing coverage with the goals of expanding access to and improving the quality of health coverage.

Revenue Impact of Final Rules

This section of the preamble discusses the revenue impact of the final rules, considers a variety of approaches that employers offering grandfathered health plan coverage might have taken if the 2015 final rules were not amended, and compares the revenue impact of each approach under the 2015 final rules with the revenue impact under the final rules.

a. Employees Who Would Have Remained in Grandfathered Plans and Coverage Without the Final Rules

If the 2015 final rules were not amended, some employers might have chosen to continue to maintain their grandfathered health plan coverage. This subsection discusses the revenue impact that the final rules may have on this group of employers and employees.

Under the final rules, grandfathered group health plans and grandfathered group health insurance coverage will be allowed to increase fixed-amount cost-sharing requirements (such as copayments, deductibles, and out-of-

pocket limits) at a somewhat higher rate than under the 2015 final rules without losing grandfather status, which may result in a premium reduction (or similar cost reduction for a self-insured plan). Specifically, for increases in fixed-amount cost-sharing on or after the applicability date of the final rules, grandfathered group health plans and grandfathered group health insurance coverage may use an alternative standard for determining the maximum percentage increase that relies on the premium adjustment percentage, rather than medical inflation, to the extent that it yields a greater result than the standard under the 2015 final rules.

The premium adjustment percentage is estimated to be about three percentage points higher than medical inflation in 2026, using FY2021 President's Budget projections of medical CPI and National Health Expenditures premium projections. Therefore, as of that year, fixed-amount copayments, deductibles, and out-of-pocket limits could be three percentage points higher under the final rules than under the 2015 final rules. However, a grandfathered group plan that increases fixed-amount cost-sharing to the maximum amount allowed under the final rules is likely to realize only a small reduction in premiums. This is because plans incur most of their costs for a relatively small fraction of participants—that is, from high-cost individuals. Because high-cost individuals generally exceed the out-of-pocket limit for the year, they are only modestly affected by higher out-of-pocket limits. Low-cost individuals are more likely to be affected by an increase in fixed-amount cost-sharing, but they incur a small portion of the overall costs. Therefore, the impact of the final rules for a particular grandfathered group health plan will depend on the parameters of covered benefits under the plan, as well as the distribution of expenditures for the plan participants. In addition, increased cost sharing could result in participants and beneficiaries making fewer visits to providers (that is, lower utilization), which could result in lower medical costs for some individuals, but higher costs for others who delay needed medical care. If individuals generally forgo unnecessary care, but continue to go to providers when necessary, premiums could decline even more, but this outcome is uncertain.

Because of the Federal tax exclusion for employer-sponsored coverage, a premium reduction would increase tax revenues due to reduced employer contributions and employee pre-tax contributions made through a cafeteria plan. However, some employees might partially offset their increases in out-of-pocket payments through increased pre-tax contributions to health flexible spending arrangements (FSAs) or HSAs. Those potential increases in pre-tax contributions to health FSAs and HSAs would reduce tax revenues. Nonetheless, to the extent that employers would have continued to offer a grandfathered group health plan without changes to the 2015 final rules, under these final rules, the Departments expect tax revenues may increase slightly on net as a result of potential premium reductions. Further, there would be additional revenue gains to the extent that higher out-of-pocket payments discourage employees from continuing participation in the employer's group health plan. This increase may be offset by a reduction in revenue, however, if a reduction in premiums encourages non-participant employees to obtain coverage.

b. Employees Who Would No Longer Have Been Covered by Grandfathered Group Health Plans or Coverage Without the Final Rules

If the 2015 final rules were not amended, some employers might have chosen to change their insured grandfathered group health plans to self-insured, non-grandfathered group health plans, rather than continue to comply with the 2015 final rules, which would result in little, if any, revenue change. Thus, with respect to these employers, the adoption of the final rules will have little, if any, revenue effect.

Alternatively, assuming the 2015 final rules were not amended, an employer might switch to a fully insured non-grandfathered non-HDHP group health plan. With respect to small employers, employees who would transfer to the non-grandfathered group health plan could improve the small group market risk pool or make it worse. An employer with a healthy population might be more likely to self-insure, whereas a small employer with a less healthy population might be more likely to join an insurance pool.

One commenter stated that because the non-grandfathered small group market is subject to modified community rating and single risk pool requirements, making it easier for small-group health plans to preserve their grandfather status would encourage firms with younger or healthier employees to find ways to opt out of the non-grandfathered small group market, at the expense of other firms that then would face higher premiums. The commenter noted that because premiums and medical claims costs in the small group market are higher for plans that are subject to all PPACA market reforms than for plans that are not, and because PPACA's changes to plan standards in the small group market were more significant than in the large group market, employees at small businesses have more to lose when employers avoid most PPACA market reforms. The commenter suggested that further extending grandfather status would only contribute to market segmentation that harms the non-grandfathered small-group market, rather than channeling younger and healthier groups into the insurance markets that generally are subject to PPACA market reforms, which would serve to bolster stability in those markets.

The Departments acknowledge that the existence of grandfathered group health plans potentially creates market segmentation in the small group market. However, to the extent such market segmentation exists, the Departments do not anticipate that the additional flexibilities provided in the final rules will increase segmentation since the final rules do not provide any mechanism for non-grandfathered plans to become grandfathered. Moreover, the Departments do not expect the number of plans that maintain grandfather status because of the final rules to be so significant as to exacerbate any market segmentation that may already exist.

Although the type of benefits covered in new, non-grandfathered plans (whether self-insured or fully insured) would likely be broader in some ways, such as for preventive care, the share of costs covered by the plan would likely decrease due to higher cost-sharing. Presumably, if the 2015 final rules were not amended, most employers would not make the switch from a grandfathered group health plan to a non-grandfathered group health plan unless the overall cost of providing benefits would decrease, which would cause some revenue gain. (Again, though, the revenue gain could be partially offset by increases in the employees' pre-tax contributions to health FSAs or HSAs.) On the other hand, if the final rules enable an employer that otherwise might switch to a non-grandfathered group health plan to retain its grandfather plan, this revenue gain would not occur, resulting in a revenue loss compared to the status quo under the 2015 final rules.

Without the change to the 2015 final rules, some employers might replace their grandfathered group health plan with an individual coverage health reimbursement arrangement (individual coverage HRA). If the employer contributes a similar dollar amount to

the individual coverage HRA as it currently does to the grandfathered group health plan, the employees' tax exclusion would be at least roughly the same as for the grandfathered group health plan. Moreover, the employees offered the individual coverage HRA would be as likely to be ''firewalled'' from obtaining a premium tax credit as if they had continued to participate in the grandfathered group health plan. Thus, under this scenario, there would be very little revenue effect from the final rules.

c. Termination of Employer-Sponsored Coverage

If the 2015 final rules were not amended, some employers might drop grandfathered group health coverage altogether and opt instead to make an employer shared responsibility payment, if required under section 4980H of the Code, which may result in an increase in federal revenue. In this case, all affected employees would qualify for a special enrollment period to enroll in other group coverage, if available, or individual health insurance coverage on or off the Exchange. Many of those employees with household incomes between 100–400 percent of the federal poverty level might qualify for financial assistance to help pay for their Exchange coverage and related healthcare expenses, which would increase federal outlays, as discussed further later in this section. Others might have household incomes too high to be eligible for a premium tax credit or might receive a smaller tax subsidy through the income-related premium tax credit than through an employer-sponsored health insurance tax exclusion. Accordingly, if these employers continue their grandfathered group health plan under the final rules, there may be an associated revenue loss. Other employees could purchase individual health insurance coverage but receive a premium tax credit that is greater than the value of the tax exclusion for their current employer plans. For this population, the final rules may result in a revenue gain. However, the employees for which there would be a revenue gain are likely a small population for an employer that is currently offering a grandfathered group health plan.

Despite the availability of a special enrollment period, some affected employees might forgo enrolling in alternative health coverage and become uninsured or might opt instead to purchase short-term, limited-duration insurance. In this case, these employees would no longer receive a tax exclusion for the grandfathered group health plan, which, along with an employer shared responsibility payment, if any, may result in an increase in federal tax revenue. However, if these employees were to remain covered under a grandfathered group health plan as a result of the final rule, there may be a loss in federal revenue for this group.

Overall, there are a number of potential revenue effects of the final rules, some of which could offset each other. Additionally, there is a large degree of uncertainty, including uncertainty regarding how many group health plans would have continued as grandfathered plans absent the final rules and what alternatives would have been chosen by employers who would not have kept grandfathered group health plans absent the final rules, as well as how many grandfathered group health plans will make plan design changes as a result of the final rules. As a result, it is unclear whether these effects in the aggregate would result in a revenue gain or revenue loss. Because the employer market is so large, even a small percentage change to aggregate premiums can result in large revenue changes. Nevertheless, the Departments are of the view that overall net effects are likely to be relatively small.

Regulatory Review Costs

Affected entities will need to understand the requirements of the final rules before they can avail themselves of any of the flexibilities in the final rules. Sponsors and issuers of grandfathered group health plan coverage will be responsible for ensuring compliance with the final rules should they seek to make changes to their grandfathered group health plans' cost-sharing requirements.

If regulations impose administrative costs on private entities, such as the time needed to read and interpret the final rules, the Departments seek to estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review and interpret the final rules, the Departments assume that the total number of grandfathered group health plan coverage sponsors and issuers that will be able to avail themselves of the flexibilities provided by the final rules is a fair estimate of the number of entities affected. The Departments estimate 414,288 grandfathered plan sponsors and issuers of grandfathered group health insurance coverage will incur burdens related to reviewing the final rules.

The Departments acknowledge that this assumption may understate or overstate the costs of reviewing the final rules. It is possible that not all affected entities will review the final rules in detail and that others may seek the assistance of outside counsel to read and interpret the final rules. For example, firms providing or sponsoring a grandfathered group health plan may not read the final rules and might rely upon an issuer or a third-party administrator, if self-funded, to read and interpret the final rules. For these reasons, the Departments are of the view that the number of grandfathered group health plan coverage sponsors and issuers is a fair estimate of the number of reviewers of the final rules. The Departments sought, but did not receive, comments on the approach to estimating the number of affected entities that will review and interpret the final rules.

Using the wage information from the Bureau of Labor and Statistics (BLS) for a Compensation and Benefits Manager (Code 11–3111), the Departments estimate that the cost of reviewing the final rules is $129.04 per hour, including overhead and fringe benefits.[32] Assuming an average reading speed, the Departments estimate that it would take approximately 0.5 hour for the staff to review and interpret the final rules; therefore, the Departments estimate that the cost of reviewing and interpreting the final rules for each grandfathered group health plan coverage sponsor and issuer is approximately $64.52. Thus, the Departments estimate that the overall cost for the estimated 414,288 grandfathered group health plan coverage sponsors and issuers will be $26,729,861.76 ($64.52 * 414,288 total number of estimated grandfathered plan sponsors and issuers).[33]

D. Regulatory Alternatives Considered

In developing the policies contained in the final rules, the Departments considered alternatives to the final rules. In the following paragraphs, the Departments discuss the key regulatory alternatives considered.

[32] Wage information is available at *https://www.bls.gov/oes/current/oes_nat.htm.* Hourly wage rate is determining by multiplying the mean hourly wage by 100 percent to account for overhead and fringe benefits. The mean hourly wage for a Compensation and Benefit Manager (Code 11–3111) is $64.52, when multiplied by 100 percent results in a total adjusted hourly wage of $129.04.

[33] The total number of grandfathered plan sponsors and issuers of grandfathered group health insurance coverage, discussed earlier in the preamble, was derived from the total number of ERISA covered plan sponsors multiplied by the percentage of entities offering grandfathered health plans (2.5 million * 0.16 = 400,000), the number of state and local governments multiplied by the percentage of entities offering grandfathered health plans (84,087 * 0.16 = 13,454), and the 834 issuers offering at least one grandfathered health plan (400,000 + 13,454 + 843 = 414,288).

The Departments considered whether to modify each of the six types of changes, measured from March 23, 2010, that cause a group health plan or group health insurance coverage to cease to be grandfathered. To provide more flexibility regarding changes to fixed cost-sharing requirements, the Departments considered revising the definition of maximum percentage increase to increase the allowed percentage points that are added to medical inflation. However, the Departments are of the view that the final rules allow for the desired flexibility, while better reflecting underlying costs for grandfathered group health plans and grandfathered group health insurance coverage. The Departments acknowledge that the premium adjustment percentage, which the Departments incorporate into the definition of maximum percentage increase, reflects the changes in premiums in both the individual and group market, and that individual market premiums have increased faster than premiums in the group market. Due to the comparative sizes of the individual and group markets, however, the historically faster growth in the individual market has had a minimal impact on the premium adjustment percentage index. Therefore, the Departments are of the view that the premium adjustment percentage is an appropriate measure to incorporate into the definition of maximum percentage increase.

Another option the Departments considered was allowing a decrease in contribution rates by an employer or employee organization without triggering a loss of grandfather status. Under the 2015 final rules, an employer or employee organization cannot decrease contribution rates based on cost of coverage toward the cost of any tier of coverage for any class of similarly situated individuals by more than five percentage points below the contribution rate for the coverage period that included March 23, 2010 without losing grandfather status. The Departments considered permitting group health plans and group health insurance coverage with grandfather status to decrease the contribution rates by more than five percentage points. This change would increase employer flexibility, but the Departments were concerned that a decrease in the contribution rate could change the plan or coverage to such an extent that the plan or coverage could not reasonably be described as being the same plan or coverage that was offered on March 23, 2010. As a result, this option was not included in the final rules.

Another option the Departments considered was allowing a change to annual dollar limits for a group health plan or health insurance coverage without triggering a loss of grandfather status. Under the 2015 final rules, a group health plan or group health insurance coverage that did not have an annual dollar limit on March 23, 2010, may not establish an annual dollar limit for any individual, whether provided in-network or out-of-network, without relinquishing grandfather status. If the plan or coverage had an annual dollar limit on March 23, 2010, it may not decrease the limit. Although for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers generally may no longer impose annual or lifetime dollar limits on essential health benefits, permitting changes to annual dollar limits on benefits that are not essential health benefits may still represent a significant change to participants and beneficiaries who rely upon the benefits to which a limit is applied. Therefore, this option was not included in the final rules.

The Departments considered options to offset cost-sharing requirement changes by allowing sponsors of grandfathered group health plans and issuers of grandfathered group health insurance coverage to increase different types of cost-sharing requirements as long as any increase is offset by lowering another cost-sharing requirement to preserve the plan's or coverage's actuarial value. As discussed in previous rulemaking, however, an actuarial equivalency standard would allow a plan or coverage to make fundamental changes to the benefit design and still retain grandfather status, potentially conflicting with the goal of allowing participants and beneficiaries to retain health plans they like.[34] There would also be significant complexity involved in defining and determining actuarial value for these purposes, as well as significant burdens associated with administering and ensuring compliance with such rules. Therefore, the Departments did not include this option in the final rules.

The Departments considered changing the date of measurement for calculating whether changes to group health plans or health insurance coverage will cause a loss of grandfather status. For example, instead of looking at the cumulative change from March 23, 2010, the rules could measure the annual increases, starting from the applicability date of the final rules. However, the Departments concluded that this option could limit flexibility for some employers. For example, some employers might want to keep the terms of the grandfathered group health plan the same for a few years and then make a more significant change later.

The Departments also considered making changes to the 2015 final rules to encourage more cost-effective care. One option the Departments considered was allowing unlimited changes to cost-sharing for out-of-network benefits. However, the Departments are concerned that unlimited discretion to change cost-sharing requirements for out-of-network benefits could result in changes to grandfathered group health plans or coverages so extensive that these plans or coverages could not reasonably be described as being the same plans or coverages that were offered on March 23, 2010. Additionally, the Departments decided that the change in the applicable index for medical inflation provides sufficient flexibility for fixed cost-sharing requirements. This option will give flexibility to grandfathered group health plans and grandfathered group health insurance coverage with respect to all fixed-amount cost-sharing requirements, including for out-of-network benefits.

E. Collection of Information Requirements

The final rules do not impose new information collection requirements; that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*). Though the final rules do not contain any new information collection requirements, the Departments are maintaining the current requirements that grandfathered plans maintain records documenting the terms of the plan in effect on March 23, 2010, include a statement in any summary of benefits that the plan or coverage believes it is grandfathered health plan coverage and that plans and coverages must provide contact information for participants to direct questions and complaints. Additionally, the Departments are maintaining the requirement that a grandfathered group health plan that is changing health insurance issuers must provide the succeeding health insurance issuer documentation of plan terms under the prior health insurance coverage sufficient to determine whether the standards of paragraph 26 CFR 54.9815–1251(g)(1), 29 CFR 2590.715–1251(g)(1) and 45 CFR 147.140(g)(1) are met, and

[34] 75 FR 34538, 34547 (June 17, 2010).

that insured group health plans (or multiemployer plans) that are grandfathered plans are required to notify the issuer (or multiemployer plan) if the contribution rate changes at any point during the plan year. The Departments do not anticipate that the final rules will make a substantive or material modification to the collections currently approved under the collection of information OMB control number 0938–1093 (CMS–10325), OMB control number 1210–0140 (DOL), and OMB control number 1545–2178 (Department of the Treasury).

F. Regulatory Flexibility Act

The Regulatory Flexibility Act, (5 U.S.C. 601, *et seq.*), requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of final rules on small entities, unless the head of the agency can certify that the rules would not have a significant economic impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of ''small entity.'' HHS uses a change in revenues of more than three to five percent as its measure of significant economic impact on a substantial number of small entities.

The final rules amend the 2015 final rules to allow greater flexibility for grandfathered group health plans and issuers of grandfathered group health insurance coverage. Specifically, the final rules specify that grandfathered group health plans that are HDHPs may make changes to fixed-amount cost-sharing requirements that would otherwise cause a loss of grandfather status without causing a loss of grandfather status, but only to the extent those changes are necessary to comply with the requirements for being HDHPs under section 223(c)(2)(A) of the Code. The final rules also include a revised definition of maximum percentage increase that will provide an alternative method of determining the maximum percentage increase that is based on the premium adjustment percentage.

G. Impact of Regulations on Small Business—Department of Health and Human Services and the Department of Labor

The Departments are of the view that health insurance issuers would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $41.5 million or less would be considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (Health Maintenance Organization (HMO) Medical Centers) and, if this is the case, the SBA size standard would be $35 million or less.[35] Few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from MLR annual report submissions for the 2019 MLR reporting year, approximately 74 out of 483 issuers of health insurance coverage nationwide had total premium revenue of $41.5 million or less.[36] This estimate may overstate the actual number of small health insurance companies that may be affected, since over 68 percent of these small companies belong to larger holding groups. Most, if not all, of these small companies are likely to have non-health lines of business that will result in their revenues exceeding $41.5 million, and it is likely not all of these companies offer grandfathered group health plans or grandfathered group health coverage. The Departments do not expect any of these 74 potentially small entities to experience a change in revenues of more than three to five percent as a result of the final rules. Therefore, the Departments do not expect the provisions of the final rules to affect a substantial number of small entities. Due to the lack of knowledge regarding what small entities may decide to do with regard to the provisions in the final rules, the Departments are not able to precisely ascertain the economic effects on small entities. However, the Departments are of the view that the flexibilities provided for in the final rules will result in overall benefits for small entities by allowing them to make changes to certain cost-sharing requirements within limits and maintain their current grandfathered group health plans. The Departments sought, but did not receive, comments on ways that the 2020 proposed rules may impose additional costs and burdens on small entities.

For purposes of analysis under the RFA, the Employee Benefits Security Administration (EBSA) continues to consider a small entity to be an employee benefit plan with fewer than 100 participants.[37] The basis of this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Under section 104(a)(3), the Secretary of Labor may also provide for exemptions or simplified annual reporting and disclosure for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the DOL has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and satisfying certain other requirements. Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, EBSA believes that assessing the impact of the final rules on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the SBA (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 *et seq.*). Therefore, EBSA requested, but did not receive, comments on the appropriateness of the size standard used in evaluating the impact of the final rules on small entities.

H. Impact of Regulations on Small Business—Department of the Treasury

Pursuant to section 7805(f) of the Code, the proposed rules that preceded these final rules were submitted to the Chief Counsel for Advocacy of the SBA for comment on their impact on small business, and no comments were received.

I. Effects on Small Rural Hospitals

Section 1102(b) of the SSA (42 U.S.C. 1302) requires agencies to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions

[35] ''Table of Small Business Size Standards Matched to North American Industry Classification System Codes.'' U.S. Small Business Administration, available at *https:/www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf.*

[36] ''Medical Loss Ratio Data and System Resources.'' CCIIO, available at *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

[37] The DOL consulted with the SBA in making this determination as required by 5 U.S.C. 603(c) and 13 CFR 121.903(c).

of section 604 of the RFA. For purposes of section 1102(b) of the SSA, HHS defines a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. The final rules would not materially affect small rural hospitals. Therefore, while the final rules are not subject to section 1102(b) of the SSA, the Departments have determined that the final rules will not have a significant impact on the operations of a substantial number of small rural hospitals.

J. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain actions before issuing a final rule that includes any federal mandate that may result in expenditures in any one year by state, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2020, that threshold is approximately $156 million.

While the Departments recognize that some state, local, and tribal governments may sponsor grandfathered health plan coverage, the Departments do not expect any state, local, or tribal government to incur any additional costs associated with the final rules. The Departments estimate that any costs associated with the final rules will not exceed the $156 million threshold. Thus, the Departments conclude that the final rules will not impose an unfunded mandate on state, local, or tribal governments or the private sector.

K. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule that imposes substantial direct costs on state and local governments, preempts state law, or otherwise has federalism implications. Federal agencies promulgating regulations that have 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, the final rules do not have any federalism implications. They simply provide grandfathered group health plan sponsors and issuers more flexibility to increase fixed-amount cost-sharing requirements and to make changes to fixed-amount cost-sharing requirements in grandfathered group health plans and grandfathered group health insurance coverage that are HDHPs to the extent those changes are necessary to comply with the requirements for HDHPs under section 223(c)(2)(A) of the Code, without causing the plan or coverage to relinquish its grandfather status. The Departments recognize that some state, local, and tribal governments may sponsor grandfathered health plan coverage. The final rules will provide these entities with additional flexibility.

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 section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements in title XXVII of the PHS Act (including those enacted by PPACA) 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 states' 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 to health insurance issuers except to the extent that such requirements prevent the application of PHS Act requirements that are the subject of this rulemaking. 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 states, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with state insurance officials on an individual basis. While developing the final rules, the Departments attempted to balance the states' interests in regulating health insurance issuers with 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 the final rules, the Departments certify that the Department of the Treasury, EBSA, and CMS have complied with the requirements of Executive Order 13132 for the attached final rules in a meaningful and timely manner.

L. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, entitled ''Reducing Regulation and Controlling Regulatory Costs,'' was issued on January 30, 2017, and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' It has been determined that the final rules are an action that primarily results in transfers and does not impose more than *de minimis* costs as described above and thus is not a regulatory or deregulatory action for the purposes of Executive Order 13771.

V. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor 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; section 101(g), Public Law 104–191, 110 Stat. 1936; section 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); section 512(d), Public Law 110–343, 122 Stat. 3881; section 1001, 1201, and 1562(e), Public Law 111–148, 124 Stat. 119, as amended by Public Law 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 regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Employee benefit plans, Health care, Health insurance, Penalties, Pensions, Privacy, Reporting and recordkeeping requirements.

45 CFR Part 147

Age discrimination, Citizenship and naturalization, Civil rights, Health care, Health insurance, Individuals with disabilities, Intergovernmental relations, Reporting and recordkeeping requirements, Sex discrimination.

Sunita Lough,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: December 7, 2020.

David J. Kautter,

Assistant Secretary of the Treasury (Tax Policy).

Dated: December 9, 2020.

Jeanne Klinefelter Wilson,

Acting Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor.

Dated: November 30, 2020.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: December 2, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Amendments to the Regulations

Accordingly, the Internal Revenue Service, Department of the Treasury, amends 26 CFR part 54 as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 continues to read, in part, as follows:

Authority: 26 U.S.C. 7805, unless otherwise noted.

* * * * *

■ **Par. 2.** Section 54.9815–1251 is as amended:

■ a. By revising the first sentence of paragraph (g)(1) introductory text;

■ b. By revising paragraphs (g)(1)(iii), (g)(1)(iv)(A) and (B), and (g)(1)(v);

■ c. By redesignating paragraphs (g)(3) and (4) as paragraphs (g)(4) and (5);

■ d. By adding a new paragraph (g)(3);

■ e. By revising newly redesignated paragraphs (g)(4)(i) and (ii); and

■ f. In newly redesignated paragraph (g)(5):

■ i. By revising Examples 3 and 4;

■ ii. By redesignating Examples 5 through 9 as Examples 6 through 10;

■ iii. By adding a new Example 5;

■ iv. By revising newly redesignated Examples 6 through 10; and

■ v. By adding Example 11.

The revisions and additions read as follows:

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

* * * * *

(g) * * *

(1) * * * Subject to paragraphs (g)(2) and (3) 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. * * *

* * * * *

(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)(4)(ii) of this section).

(iv) * * *

(A) An amount equal to $5 increased by medical inflation, as defined in paragraph (g)(4)(i) of this section (that is, $5 times medical inflation, plus $5); or

(B) The maximum percentage increase (as defined in paragraph (g)(4)(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)(4)(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(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)(4)(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(d)) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

* * * * *

(3) *Special rule for certain grandfathered high deductible health plans.* With respect to a grandfathered group health plan or group health insurance coverage that is a high deductible health plan within the meaning of section 223(c)(2), increases to fixed-amount cost-sharing requirements made effective on or after June 15, 2021 that otherwise would cause a loss of grandfather status will not cause the plan or coverage to relinquish its grandfather status, but only to the extent such increases are necessary to maintain its status as a high deductible health plan under section 223(c)(2)(A).

(4) * * *

(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 purposes of this paragraph (g)(4)(i), 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:

(A) With respect to increases for a group health plan and group health insurance coverage made effective on or after March 23, 2010, and before June 15, 2021, medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points; and

(B) With respect to increases for a group health plan and group health insurance coverage made effective on or after June 15, 2021, the greater of:

(*1*) Medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points; or

(*2*) The portion of the premium adjustment percentage, as defined in 45 CFR 156.130(e), that reflects the relative

change between 2013 and the calendar year prior to the effective date of the increase (that is, the premium adjustment percentage minus 1), expressed as a percentage, plus 15 percentage points.

* * * * *

(5) * * *

Example 3. (i) *Facts.* On March 23, 2010, a grandfathered group 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, effective before June 15, 2021. 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)(4)(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* of this paragraph (g)(5), except the grandfathered group health plan subsequently increases the $40 copayment requirement to $45 for a later plan year, effective before June 15, 2021. 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)(4)(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 × 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.* Same facts as *Example 4* of this paragraph (g)(5), except the grandfathered group health plan increases the copayment requirement to $45, effective *after* June 15, 2021. The greatest value of the overall medical care component of the CPI–U (unadjusted) in the preceding 12-month period is still 485. In the calendar year that includes the effective date of the increase, the applicable portion of the premium adjustment percentage is 36%.

(ii) *Conclusion.* In this *Example 5,* the grandfathered health plan may increase the copayment by the greater of: Medical inflation, expressed as a percentage, plus 15 percentage points; or the applicable portion of the premium adjustment percentage for the calendar year that includes the effective date of the increase, plus 15 percentage points. The latter amount is greater because it results in a 51% maximum percentage increase (36% + 15% = 51%) and, as demonstrated in *Example 4* of this paragraph (g)(5), determining the maximum percentage increase using medical inflation yields a result of 40.27%. The increase in the copayment, expressed as a percentage, is 50% (45 − 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Because the 50% increase in the copayment is less than the 51% maximum percentage increase, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 6. (i) *Facts.* On March 23, 2010, a grandfathered group 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, effective before June 15, 2021. 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 6,* 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)(4)(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 group 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 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 6* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to $5.36.

Example 7. (i) *Facts.* Same facts as *Example 6* of this paragraph (g)(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, effective before June 15, 2021.

(ii) *Conclusion.* In this *Example 7,* medical inflation (as defined in paragraph (g)(4)(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 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 7* 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 8. (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 8,* 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 9. (i) *Facts.* On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5,000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1,000 for self-only coverage and $4,000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5,000 − 1,000)/5,000) for self-only coverage and 67% ((12,000 − 4,000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6,000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1,200 for self-only coverage and $5,000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6,000 − 1,200)/6,000) for self-only

coverage and 67% ((15,000 − 5,000)/15,000) for family coverage.

(ii) *Conclusion.* In this *Example 9,* 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.

Example 10. (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 increases coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 10,* the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

Example 11. (i) *Facts.* A group health plan that is a grandfathered health plan and also a high deductible health plan within the meaning of section 223(c)(2) had a $2,400 deductible for family coverage on March 23, 2010. The plan is subsequently amended after June 15, 2021 to increase the deductible limit by the amount that is necessary to comply with the requirements for a plan to qualify as a high deductible health plan under section 223(c)(2)(A), but that exceeds the maximum percentage increase.

(ii) *Conclusion.* In this *Example 11,* the increase in the deductible at that time does not cause the plan to cease to be a grandfathered health plan because the increase was necessary for the plan to continue to satisfy the definition of a high deductible health plan under section 223(c)(2)(A).

DEPARTMENT OF LABOR

Employee Benefits Security Administration

Accordingly, the Department of Labor amends 29 CFR part 2590 as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 3. The authority citation for part 2590 continues to read as follows:

Authority: 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; Division M, Pub. L. 113–235, 128 Stat. 2130; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 4. Amend § 2590.715–1251:
■ a. By revising the first sentence of paragraph (g)(1) introductory text;
■ b. By revising paragraphs (g)(1)(iii), (g)(1)(iv)(A) and (B), and (g)(1)(v);
■ c. By redesignating paragraphs (g)(3) and (4) as paragraphs (g)(4) and (5);
■ d. By adding a new paragraph (g)(3);
■ e. By revising newly redesignated paragraphs (g)(4)(i) and (ii); and
■ f. In newly redesignated paragraph (g)(5):
■ i. By revising Examples 3 and 4;
■ ii. By redesignating Examples 5 through 9 as Examples 6 through 10;
■ iii. By adding a new Example 5;
■ iv. By revising newly redesignated Examples 6 through 10; and
■ v. By adding Example 11.

The revisions and additions read as follows:

§ 2590.715–1251 Preservation of right to maintain existing coverage.

* * * * *

(g) * * *

(1) * * * Subject to paragraphs (g)(2) and (3) 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. * * *

* * * * *

(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)(4)(ii) of this section).

(iv) * * *

(A) An amount equal to $5 increased by medical inflation, as defined in paragraph (g)(4)(i) of this section (that is, $5 times medical inflation, plus $5); or

(B) The maximum percentage increase (as defined in paragraph (g)(4)(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)(4)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 2590.702(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)(4)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 2590.702(d)) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

* * * * *

(3) *Special rule for certain grandfathered high deductible health plans.* With respect to a grandfathered group health plan or group health insurance coverage that is a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code, increases to fixed-amount cost-sharing requirements made effective on or after June 15, 2021 that otherwise would cause a loss of grandfather status will not cause the plan or coverage to relinquish its grandfather status, but only to the extent such increases are necessary to maintain its status as a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code.

(4) * * *

(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 purposes of this paragraph (g)(4)(i), 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:

(A) With respect to increases for a group health plan and group health insurance coverage made effective on or after March 23, 2010, and before June 15, 2021, medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points; and

(B) With respect to increases for a group health plan and group health insurance coverage made effective on or after June 15, 2021, the greater of:

(*1*) Medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points; or

(*2*) The portion of the premium adjustment percentage, as defined in 45 CFR 156.130(e), that reflects the relative change between 2013 and the calendar year prior to the effective date of the increase (that is, the premium adjustment percentage minus 1), expressed as a percentage, plus 15 percentage points.

* * * * *

(5) * * *

Example 3. (i) *Facts.* On March 23, 2010, a grandfathered group 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, effective before June 15, 2021. 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)(4)(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* of this paragraph (g)(5), except the grandfathered group health plan subsequently increases the $40 copayment requirement to $45 for a later plan year, effective before June 15, 2021. 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)(4)(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 × 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.* Same facts as *Example 4* of this paragraph (g)(5), except the grandfathered group health plan increases the copayment requirement to $45, effective *after* June 15, 2021. The greatest value of the overall medical care component of the CPI–U (unadjusted) in the preceding 12-month period is still 485. In the calendar year that includes the effective date of the increase, the applicable portion of the premium adjustment percentage is 36%.

(ii) *Conclusion.* In this *Example 5,* the grandfathered health plan may increase the copayment by the greater of: Medical inflation, expressed as a percentage, plus 15 percentage points; or the applicable portion of the premium adjustment percentage for the calendar year that includes the effective date of the increase, plus 15 percentage points. The latter amount is greater because it results in a 51% maximum percentage increase (36% + 15% = 51%) and, as demonstrated in *Example 4* of this paragraph (g)(5), determining the maximum percentage increase using medical inflation yields a result of 40.27%. The increase in the copayment, expressed as a percentage, is 50% (45 − 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Because the 50% increase in the copayment is less than the 51% maximum percentage increase, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 6. (i) *Facts.* On March 23, 2010, a grandfathered group 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, effective before June 15, 2021. 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 6,* 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)(4)(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 group 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 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 6* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to $5.36.

Example 7. (i) *Facts.* Same facts as *Example 6* of this paragraph (g)(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, effective before June 15, 2021.

(ii) *Conclusion.* In this *Example 7,* medical inflation (as defined in paragraph (g)(4)(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 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 7* 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 8. (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 8,* 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 9. (i) *Facts.* On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5,000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1,000 for self-only coverage and $4,000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5,000 − 1,000)/5,000) for self-only coverage and 67% ((12,000 − 4,000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6,000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1,200 for self-only coverage and $5,000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6,000 − 1,200)/6,000) for self-only coverage and 67% ((15,000 − 5,000)/15,000) for family coverage.

(ii) *Conclusion.* In this *Example 9,* 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 10. (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 increases coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 10,* the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

Example 11. (i) *Facts.* A group health plan that is a grandfathered health plan and also a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code had a $2,400 deductible for family coverage on March 23, 2010. The plan is subsequently amended after June 15, 2021 to increase the deductible limit by the amount that is necessary to comply with the requirements for a plan to qualify as a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code, but that exceeds the maximum percentage increase.

(ii) *Conclusion.* In this *Example 11,* the increase in the deductible at that time does not cause the plan to cease to be a grandfathered health plan because the increase was necessary for the plan to continue to satisfy the definition of a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR part 147 as set forth below:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 5. The authority citation for part 147 continues to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended, and section 3203, Pub. L. 116–136, 134 Stat. 281.

■ 6. Section 147.140 is amended:
■ a. By revising the first sentence of paragraph (g)(1) introductory text;
■ b. By revising paragraphs (g)(1)(iii), (g)(1)(iv)(A) and (B), and (g)(1)(v);
■ c. By redesignating paragraphs (g)(3) and (4) as paragraphs (g)(4) and (5);
■ d. By adding a new paragraph (g)(3);
■ e. By revising newly redesignated paragraphs (g)(4)(i) and (ii); and
■ f. In newly redesignated paragraph (g)(5):
■ i. By revising Examples 3 and 4;
■ ii. By redesignating Examples 5 through 9 as Examples 6 through 10;
■ iii. By adding a new Example 5;
■ iv. By revising newly redesignated Examples 6 through 10;
■ v. By adding Example 11.

The revisions and additions read as follows:

§ 147.140 Preservation of right to maintain existing coverage.

* * * * *

(g) * * *

(1) * * * Subject to paragraphs (g)(2) and (3) 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. * * *

* * * * *

(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)(4)(ii) of this section).

(iv) * * *

(A) An amount equal to $5 increased by medical inflation, as defined in paragraph (g)(4)(i) of this section (that is, $5 times medical inflation, plus $5); or

(B) The maximum percentage increase (as defined in paragraph (g)(4)(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)(4)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 146.121(d) of this subchapter) 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)(4)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 146.121(d) of this subchapter) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

* * * * *

(3) *Special rule for certain grandfathered high deductible health plans.* With respect to a grandfathered group health plan or group health insurance coverage that is a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code, increases to fixed-amount cost-sharing requirements made effective on or after June 15, 2021 that otherwise would cause a loss of grandfather status will not cause the plan or coverage to relinquish its grandfather status, but only to the extent such increases are necessary to maintain its status as a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code.

(4) * * *

(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 purposes of this paragraph (g)(4)(i), 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:

(A) With respect to increases for a group health plan and group health insurance coverage made effective on or after March 23, 2010, and before June 15, 2021, medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points;

(B) With respect to increases for a group health plan and group health insurance coverage made effective on or after June 15, 2021, the greater of:

(*1*) Medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points; or

(*2*) The portion of the premium adjustment percentage, as defined in § 156.130(e) of this subchapter, that reflects the relative change between 2013 and the calendar year prior to the effective date of the increase (that is, the premium adjustment percentage minus 1), expressed as a percentage, plus 15 percentage points; and

(C) With respect to increases for individual health insurance coverage, medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points.

* * * * *

(5) * * *

Example 3. (i) *Facts.* On March 23, 2010, a grandfathered group 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, effective before June 15, 2021. 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)(4)(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* of this paragraph (g)(5), except the grandfathered group health plan subsequently increases the $40 copayment requirement to $45 for a later plan year, effective before June 15, 2021. 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)(4)(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 × 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.* Same facts as *Example 4* of this paragraph (g)(5), except the grandfathered group health plan increases the copayment requirement to $45, effective *after* June 15, 2021. The greatest value of the overall medical care component of the CPI–U (unadjusted) in the preceding 12-month period is still 485. In the calendar year that includes the effective date of the increase, the applicable portion of the premium adjustment percentage is 36%.

(ii) *Conclusion.* In this *Example 5,* the grandfathered health plan may increase the copayment by the greater of: Medical inflation, expressed as a percentage, plus 15 percentage points; or the applicable portion of the premium adjustment percentage for the calendar year that includes the effective date of the increase, plus 15 percentage points. The latter amount is greater because it results in a 51% maximum percentage increase (36% + 15% = 51%) and, as demonstrated in *Example 4* of this paragraph (g)(5), determining the maximum percentage increase using medical inflation yields a result of 40.27%. The increase in the copayment, expressed as a percentage, is 50% (45 − 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Because the 50% increase in the copayment is less than the 51% maximum percentage increase, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 6. (i) *Facts.* On March 23, 2010, a grandfathered group 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, effective before June 15, 2021. 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 6,* 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)(4)(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 group 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 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 6* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to $5.36.

Example 7. (i) *Facts.* Same facts as *Example 6* of this paragraph (g)(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, effective before June 15, 2021.

(ii) *Conclusion.* In this *Example 7,* medical inflation (as defined in paragraph (g)(4)(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 × 0.0720 = $0.36;

$0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 7* 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 8. (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 8,* 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 9. (i) *Facts.* On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5,000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1,000 for self-only coverage and $4,000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5,000 − 1,000)/5,000) for self-only coverage and 67% ((12,000 − 4,000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6,000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1,200 for self-only coverage and $5,000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6,000 − 1,200)/6,000) for self-only coverage and 67% ((15,000 − 5,000)/15,000) for family coverage.

(ii) *Conclusion.* In this *Example 9,* 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 10. (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 increases coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 10,* the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

Example 11. (i) *Facts.* A group health plan that is a grandfathered health plan and also a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code had a $2,400 deductible for family coverage on March 23, 2010. The plan is subsequently amended after June 15, 2021 to increase the deductible limit by the amount that is necessary to comply with the requirements for a plan to qualify as a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code, but that exceeds the maximum percentage increase.

(ii) *Conclusion.* In this *Example 11,* the increase in the deductible at that time does not cause the plan to cease to be a grandfathered health plan because the increase was necessary for the plan to continue to satisfy the definition of a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code.

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PENSION BENEFIT GUARANTY CORPORATION

29 CFR Part 4044

Allocation of Assets in Single-Employer Plans; Interest Assumptions for Valuing Benefits

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Final rule.

SUMMARY: This final rule amends the Pension Benefit Guaranty Corporation's regulation on Allocation of Assets in Single-Employer Plans to prescribe interest assumptions under the asset allocation regulation for plans with valuation dates in the first quarter of 2021. These interest assumptions are used for valuing benefits under terminating single-employer plans and for other purposes.

DATES: Effective January 1, 2021.

FOR FURTHER INFORMATION CONTACT: Gregory Katz (*katz.gregory@pbgc.gov*), Attorney, Regulatory Affairs Division, Pension Benefit Guaranty Corporation, 1200 K Street NW, Washington, DC 20005, 202–229–3829. (TTY users may call the Federal relay service toll free at 1–800–877–8339 and ask to be connected to 202–229–3829.)

SUPPLEMENTARY INFORMATION: PBGC's regulation on Allocation of Assets in Single-Employer Plans (29 CFR part 4044) prescribes actuarial assumptions—including interest assumptions—for valuing benefits under terminating single-employer plans covered by title IV of the Employee Retirement Income Security Act of 1974 (ERISA). The interest assumptions in the regulation are also published on PBGC's website (*https://www.pbgc.gov*).

PBGC uses the interest assumptions in appendix B to part 4044 (''Interest Rates Used to Value Benefits'') to determine the present value of annuities in an involuntary or distress termination of a single-employer plan under the asset allocation regulation. The assumptions are also used to determine the value of multiemployer plan benefits and certain assets when a plan terminates by mass withdrawal in accordance with PBGC's regulation on Duties of Plan Sponsor Following Mass Withdrawal (29 CFR part 4281).

The first quarter 2021 interest assumptions will be 1.69 percent for the first 20 years following the valuation date and 1.66 percent thereafter. In comparison with the interest assumptions in effect for the fourth quarter of 2020, these interest assumptions represent no change in the select period (the period during which the select rate (the initial rate) applies), an increase of 0.07 percent in the select rate, and an increase of 0.26 percent in the ultimate rate (the final rate).

Need for Immediate Guidance

PBGC has determined that notice of, and public comment on, this rule are impracticable, unnecessary, and contrary to the public interest. PBGC routinely updates the interest assumptions in appendix B of the asset allocation regulation each quarter so that they are available to value benefits. Accordingly, PBGC finds that the public interest is best served by issuing this rule expeditiously, without an opportunity for notice and comment, and that good cause exists for making the assumptions set forth in this amendment effective less than 30 days after publication to allow the use of the proper assumptions to estimate the value of plan benefits for plans with valuation dates early in the first quarter of 2021.

PBGC has determined that this action is not a ''significant regulatory action'' under the criteria set forth in Executive Order 12866.