

INTERNAL REVENUE BULLETIN



HIGHLIGHTS OF THIS ISSUE

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

ADMINISTRATIVE

Announcement 2020-8, page 244.

Announcement 2020-8 amends Revenue Procedure 2020-35 to show correct information.

1. In Section 2.1.1, Online Fillable Forms, under the heading Specifications. Delete Form 1099-NEC from the first paragraph.
2. In Section 4.5.3, Perforations, under the heading Miscellaneous Instructions for Copies B, C, D, E, 1, and 2. Indicate that instructions for perforation can be found in Section 2.1.9.

Announcement 2020-9, page 244.

The Office of Professional Responsibility (OPR) announces recent disciplinary sanctions involving attorneys, certified public accountants, enrolled agents, enrolled actuaries, enrolled retirement plan agents, and appraisers. These individuals are subject to the regulations governing practice before the Internal Revenue Service (IRS), which are set out in Title 31, Code of Federal Regulations, Part 10, and which are published in pamphlet form as Treasury Department Circular No. 230. The regulations prescribe the duties and restrictions relating to such practice and prescribe the disciplinary sanctions for violating the regulations.

T.D. 9903, page 235.

The guidance contains final regulations relating to the imposition of certain user fees on tax return preparers. Pursuant to the guidelines in OMB Circular A-25, the IRS has recalculated its cost of providing PTINs and has determined that the full cost of administering the PTIN program going forward has been reduced. Therefore, the final regulations reduce the amount of the user fee to obtain or renew a PTIN from \$33 to \$21, plus \$14.95 payable directly to a third-party contractor.

Bulletin No. 2020-32
August 3, 2020

EMPLOYEE PLANS

Notice 2020-57, page 240.

This notice sets forth updates on the corporate bond monthly yield curve, the corresponding spot segment rates for July 2020 used under § 417(e)(3)(D), the 24-month average segment rates applicable for July 2020, and the 30-year Treasury rates, as reflected by the application of § 430(h)(2)(C) (iv).

REG-130081-19, page 246.

These proposed rules would amend the 2015 regulations under Treas. Reg. § 54.9815-1251 to provide additional flexibility for grandfathered group health plans and issuers of grandfathered group health plans to make certain changes without losing their grandfathered status under the regulations.

EXEMPT ORGANIZATIONS

Notice 2020-56, page 239.

This notice amplifies the relief provided in Notice 2020-23, 2020-18 IRB 742, for hospital organizations that are required to meet the community health needs assessment (CHNA) requirements under section 501(r)(3) of the Code. Notice 2020-23 postponed until July 15, 2020, the deadline for performing any CHNA requirement that is due to be completed on or after April 1, 2020, and before July 15, 2020. This notice provides a further postponement, until December 31, 2020, of the deadline for performing any CHNA requirement due to be completed on or after April 1, 2020, and before December 31, 2020. However, the due date for any CHNA requirement originally due to be completed after December 31, 2020, is not extended by this notice.

INCOME TAX

Rev. Proc. 2020-36, page 243.

This Revenue Procedure updates the applicable percentage table in § 36B(b)(3)(A)(i) (Applicable Percentage Table) for calendar year 2021, which is used to calculate an individual's premium tax credit. The revenue procedure also updates the required contribution percentage in § 36B(c)(2)(C)(i)(II) for plan years beginning after calendar year 2020 (Section 36B Required Contribution Percentage). This percentage is used

to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage under § 36B.

Rev. Rul. 2020-15, page 233.

Federal rates; adjusted federal rates; adjusted federal long-term rate, the long-term exempt rate, and the blended annual rate. For purposes of sections 382, 1274, 1288, 7872 and other sections of the Code, tables set forth the rates for August 2020.

The IRS Mission

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

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

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

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

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

against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

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

Part II.—Treaties and Tax Legislation.

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

Part III.—Administrative, Procedural, and Miscellaneous.

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

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

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

The contents of this publication are not copyrighted and may be reprinted freely. A citation of the Internal Revenue Bulletin as the source would be appropriate.

Part I

Section 1274.— Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

(Also Sections 42, 280G, 382, 467, 468, 482, 483,
1288, 7520, 7872.)

Rev. Rul. 2020-15

This revenue ruling provides various
prescribed rates for federal income tax

purposes for August 2020 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropri-

ate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, shall not be less than 9%. Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

REV. RUL. 2020-15 TABLE 1
Applicable Federal Rates (AFR) for August 2020
Period for Compounding

	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
		<i>Short-term</i>		
AFR	0.17%	0.17%	0.17%	0.17%
110% AFR	0.19%	0.19%	0.19%	0.19%
120% AFR	0.20%	0.20%	0.20%	0.20%
130% AFR	0.22%	0.22%	0.22%	0.22%
		<i>Mid-term</i>		
AFR	0.41%	0.41%	0.41%	0.41%
110% AFR	0.45%	0.45%	0.45%	0.45%
120% AFR	0.49%	0.49%	0.49%	0.49%
130% AFR	0.53%	0.53%	0.53%	0.53%
150% AFR	0.62%	0.62%	0.62%	0.62%
175% AFR	0.72%	0.72%	0.72%	0.72%
		<i>Long-term</i>		
AFR	1.12%	1.12%	1.12%	1.12%
110% AFR	1.23%	1.23%	1.23%	1.23%
120% AFR	1.34%	1.34%	1.34%	1.34%
130% AFR	1.47%	1.46%	1.46%	1.46%

REV. RUL. 2020-15 TABLE 2
Adjusted AFR for August 2020
Period for Compounding

	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
Short-term adjusted AFR	0.13%	0.13%	0.13%	0.13%
Mid-term adjusted AFR	0.31%	0.31%	0.31%	0.31%
Long-term adjusted AFR	0.85%	0.85%	0.85%	0.85%

REV. RUL. 2020-15 TABLE 3

Rates Under Section 382 for August 2020

Adjusted federal long-term rate for the current month	.85%
Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.)	.89%

REV. RUL. 2020-15 TABLE 4

Appropriate Percentages Under Section 42(b)(1) for August 2020

Note: Under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, shall not be less than 9%.

Appropriate percentage for the 70% present value low-income housing credit	7.17%
Appropriate percentage for the 30% present value low-income housing credit	3.07%

REV. RUL. 2020-15 TABLE 5

Rate Under Section 7520 for August 2020

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest	.4%
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Section 42.—Low-Income Housing Credit

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 467.—Certain Payments for the Use of Property or Services

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 483.—Interest on Certain Deferred Payments

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 280G.—Golden Parachute Payments

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 468.—Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The applicable federal short-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 1288.—Treatment of Original Issue Discount on Tax-Exempt Obligations

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 382.—Limitation on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rate is set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 482.—Allocation of Income and Deductions Among Taxpayers

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 7520.—Valuation Tables

The applicable federal mid-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

Section 7872.—Treatment of Loans With Below-Market Interest Rates

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2020. See Rev. Rul. 2020-15, page 233.

T.D. 9903

**DEPARTMENT OF THE
TREASURY**
Internal Revenue Service
26 CFR Part 300

Preparer Tax Identification Number
(PTIN) User Fee Update

AGENCY: Internal Revenue Service
(IRS), Treasury.

ACTION: Final regulations.

SUMMARY: These final regulations amend existing regulations relating to the imposition of certain user fees on tax return preparers. The final regulations reduce the amount of the user fee to apply for or renew a preparer tax identification number (PTIN) and affect individuals who apply for or renew a PTIN. The Independent Offices Appropriations Act of 1952 authorizes the charging of user fees.

DATES: *Effective date:* These regulations are effective August 17, 2020.

Applicability Date: For the date of applicability, see §300.13(d).

FOR FURTHER INFORMATION CONTACT: Michael Franklin at (202) 317-6844 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to 26 CFR part 300 regarding user fees. On April 16, 2020, a notice of proposed rulemaking (REG-117138-17) proposing to amend the regulations relating to imposing a user fee to apply for or renew a PTIN was published in the **Federal Register** (85 FR 21126). The notice proposed decreasing the amount of the user fee to apply for or renew a PTIN from \$33, plus \$17 payable to a third-party contractor, to \$21, plus \$14.95 payable to a third-party

contractor. The notice contains a detailed explanation regarding the amendments to these regulations.

Eighteen comments responding to the notice and two requests for a public hearing were received. A public hearing on the notice was held on May 26, 2020. Two commenters testified at the public hearing. After consideration of the written comments and testimony, the Department of the Treasury (Treasury Department) and the IRS have decided to adopt without modification the regulations proposed by the notice.

Summary of Comments

The eighteen comments submitted in response to the notice of proposed rulemaking are available at www.regulations.gov or upon request.

Some of the comments that were submitted did not seek modification or clarification of the user fee as set forth in the proposed regulations. Two made no reference to the proposed regulations and their content was unrelated to a PTIN user fee. Another comment supported a fee but encouraged the IRS to take enforcement actions against return preparers who do not comply with PTIN requirements. The summary of comments below addresses those comments that seek modification or clarification of the user fee as set forth in the proposed regulations.

A. Charging a User Fee and the Amount of the User Fee

Some commenters objected to the IRS imposing a user fee at all or in the amount charged by the IRS. Some supported the imposition of a fee, while others stated that the user fee was too high or too low. The IRS also received comments that requested lower user fees for certain classes of return preparers. Two comments stated that individuals with credentials should pay a reduced fee for obtaining or renewing a PTIN and two comments stated that low-volume return preparers should pay a reduced fee or no fee for obtaining or renewing a PTIN. Similarly, some commenters requested the renewal fee be lower than the amount of the initial application fee or that the IRS adopt a longer renewal period. One commenter suggest-

ed that certain return preparers with existing PTINs should not be charged for PTIN renewal.

The United States Court of Appeals for the District of Columbia Circuit has ruled that the IRS is authorized to charge a PTIN user fee because providing a PTIN (and the “associated functions”) is a service that provides a specific benefit to identifiable recipients. *Montrois v. United States*, 916 F.3d 1056 (D.C. Cir. 2019).

Under Office of Management and Budget (OMB) Circular A-25, 58 FR 38142 (July 15, 1993) (OMB Circular A-25), Federal agencies that provide services that confer benefits on identifiable recipients are to establish user fees that recover for the government the full cost of providing the service. An agency that seeks to impose a user fee for government-provided services must calculate the full cost of providing those services. Under OMB Circular A-25, a user fee should be set at an amount that recovers the full cost of providing a service, unless the OMB grants an exception. The full cost of providing a service includes both the direct and indirect costs of providing the service.

As required by OMB Circular A-25, the IRS conducted a biennial review of the PTIN user fee and determined that the full cost to the IRS to administer the PTIN program going forward was reduced to \$21 per application or renewal. These costs include all costs related to administering the PTIN program, including costs relating to PTIN misuse and maintaining the integrity of the PTIN program. A description of the categories of activities included in the PTIN user fee and specific examples of the activities included within those categories is discussed below in section *E. Costing Methodology*. The user fee to apply for or renew a PTIN does not recover costs associated with other programs.

The IRS does not incur lower costs to provide PTINs to credentialed preparers or low-volume preparers than it incurs to provide PTINs to uncredentialed preparers or high-volume preparers. Similarly, the costs to the IRS to renew a PTIN are the same as the costs to issue a new PTIN. Accordingly, the amount of the user fee should be the same regardless of the return preparer’s status and regardless of whether the application is

an original or a renewal. The Treasury Department and the IRS have determined that the annual renewal of a PTIN is the most effective renewal period. An annual renewal period ensures the IRS has up-to-date identifying information about each return preparer, which benefits return preparers, their clients, and the IRS in ensuring the timely communication of important information. Further, the annual renewal period allows the IRS to better administer the PTIN program, effectively identify and contact return preparers, and prevent the unauthorized use of PTINs, thereby benefiting return preparers and protecting taxpayers.

B. Use of a Third-Party Contractor

Several commenters objected to paying a separate fee to the third-party contractor, and some objected to the amount of the fee paid to the third-party contractor.

The third-party contractor was chosen through a competitive bidding process, and the amount of the third-party contractor's fee is reviewed and approved by the IRS. The third-party contractor's costs include more than the discrete costs of generating a number and are separate from the costs to the IRS for administering the PTIN application and renewal program. The two portions of the fee pay for different aspects of administering the PTIN program, each of which is essential to providing PTINs to tax return preparers. As discussed in the preamble to the proposed regulations, the third-party contractor performs a number of valuable functions, including processing applications to obtain or renew a PTIN and operating a call center. The IRS has determined that it is appropriate to use a third-party contractor to perform these functions.

C. Re-instituting User Fee During *Steele* Litigation

Three commenters objected to re-instituting the PTIN user fee during the pendency of the *Steele v. United States* litigation in the United States District Court for the District of Columbia.

In *Steele v. United States*, 260 F. Supp. 3d 52 (D.D.C. 2017), the United States District Court for the District of Colum-

bia concluded that the Treasury Department and the IRS lacked the statutory authority to charge a PTIN user fee and enjoined the IRS from charging a PTIN user fee. On March 1, 2019, the United States Court of Appeals for the District of Columbia Circuit reversed the district court's decision and lifted the injunction against charging the PTIN user fee. See *Montrois v. United States*, 916 F.3d 1056 (D.C. Cir. 2019) (holding that a PTIN provides tax return preparers a specific benefit by allowing them to provide an identifying number that is not a social security number on returns they prepare and stating that the permissible amount of the fee would be the same regardless of whether the specific benefit was instead the ability to prepare tax returns for compensation). In accordance with the opinion of the United States Court of Appeals for the District of Columbia Circuit, the IRS is authorized to charge a PTIN user fee for the service of providing return preparers a PTIN. Despite the ongoing litigation with respect to the amount of the user fee, the IRS is authorized to resume charging a fee because the district court's injunction was vacated. After the injunction was lifted, and in accordance with the biennial review requirement in OMB Circular A-25, the IRS has re-determined costs that the government continues to incur for providing PTINs and administering the PTIN program and re-calculated the amount of the user fee. OMB Circular A-25 states that user fees should be collected in advance of or simultaneously with the provision of a service. The PTIN user fee is collected when return preparers apply for or renew their PTINs during the application season, which begins annually in October.

D. COVID-19 Pandemic

Two commenters objected to re-instituting the fee during the COVID-19 pandemic. The demand and need for tax return preparation services should continue despite the pandemic. As return preparers continue to prepare returns, they must continue to use current PTINs to do so, and the government continues to incur costs for providing PTINs and administering the PTIN program, which should be

recovered by charging a fee. In the absence of charging a fee to return preparers, taxpayers would bear the costs the IRS incurs of providing PTINs and associated functions.

E. Costing Methodology

One commenter made a number of other objections broadly relating to the IRS's costing methodology detailed in the proposed regulations. The same commenter and one other commenter questioned the direct costs incurred by the IRS in administering the PTIN program. The IRS properly follows generally accepted accounting principles (GAAP) in calculating the full cost of administering the PTIN program in accordance with *Statement of Federal Financial Accounting Standards (SFFAS) No. 4*, which establishes internal costing standards to accurately measure and manage the full cost of Federal programs. The preamble to the proposed regulations provides the methodology by which the IRS determined the full cost of the PTIN program. It details the use of cost centers, which are the lowest organizational unit in the IRS's cost-accounting system, the implementation of various cost-measurement techniques to estimate the direct costs attributable to the PTIN program, and overhead allocation.

As described in the preamble to the proposed regulations, the IRS uses various cost-measurement techniques to estimate the direct costs attributable to the program. These techniques include using various timekeeping systems to measure the time required to accomplish activities, or using information provided by subject-matter experts on the time devoted to a program. To determine the labor and benefits cost incurred to administer the PTIN program, the IRS estimated the number of full-time employees required to conduct activities related to the PTIN program. The number of full-time employees is based on both current employment numbers and future hiring estimates. Other direct costs associated with administering the PTIN program include contract costs and travel, training, supplies, printing, and other miscellaneous costs.

The preamble to the proposed regulations also describes the staffing and other

costs incurred in administering the PTIN program. Staffing costs are incurred by the Return Preparer Office (RPO) in the IRS and relate to conducting certain suitability checks, foreign preparer processing, handling compliance and complaint activities, information technology and contract-related support, communications, budgeting and finance, and program oversight and support. Examples of the specific activities that are included within those categories include, but are not limited to, the following activities. Suitability checks include work involving specially designated nationals,¹ incarcerated return preparers, enjoined return preparers, and professional designation checks on certain individuals. Foreign preparer processing includes the IRS processing of PTIN applications for foreign persons who are not eligible to obtain a social security number and have a permanent non-U.S. address. Compliance and complaint activities include work involving compromised and misused PTINs and identity theft related PTINs, expired PTINs, legacy PTINs, ghost return preparers (returns prepared without a PTIN), processing complaints, and penalty referrals. Information technology and contract-related support activities include contract oversight, background investigations and training for contractor personnel, contractor performance reviews, records management, peak season planning and implementation, off-season system enhancements, program metrics reporting and data extracts, managing system changes, addressing system defects and data anomalies, system training materials, cloud service provider hosting, customer contact center hosting, system capacity monitoring and performance, IT coordination and remote server platform issues for e-authentication, registration system and database refinements, enterprise life cycle documentation, site visits and contractor assessments, specialized IT security training, identity theft protection, and work related to the PTIN call center. Communications activities include correspondence with return preparers, including renewal notifications,

development of system generated messaging, website messaging, FOIA posting of PTIN holder list, and stakeholder communications. Budget and finance activities include user fee review and cost modeling, payment tracking and accountability, requisitions and obligations of funds, operational budgeting and funding based on actual and projected PTIN user fee receipts, third-party contacts related to PTIN matters (requests from Congress, Treasury Inspector General for Tax Administration, and Government Accountability Office), developing and updating Internal Revenue Manual content, and certain human resources activities. Program oversight and support includes oversight and support in the RPO over these PTIN functions.

OMB Circular A-25 does not require the IRS to account for and describe activities unrelated to providing PTINs and administering the PTIN program that are not included in the costs recovered in the PTIN user fee. The IRS has accounted for all activities properly included in the PTIN user fee.

The preamble to the proposed regulations also describes how the IRS calculated the overhead rate and overhead costs. Overhead is an indirect cost of operating an organization that is not specifically identifiable with an activity. Overhead includes costs of resources that are jointly or commonly consumed by one or more organizational unit's activities but are not specifically identifiable to a single activity.

Accordingly, the proposed regulations are adopted without change.

Special Analyses

The OMB's Office of Information and Regulatory Analysis has determined that these regulations are significant and subject to review under section 6(b) of Executive Order 12866.

Pursuant to the Regulatory Flexibility Act (5 U.S.C. chapter 6), it is hereby certified that these final regulations will not have a significant economic impact on a substantial number of small entities. The final regulations affect all individuals

who prepare or assist in preparing all or substantially all of a tax return or claim for refund for compensation. Only individuals, not businesses, can have a PTIN. Thus, the economic impact of these regulations on any small entity generally will be a result of an individual tax return preparer who is required to have a PTIN owning a small business or a small business otherwise employing an individual tax return preparer who is required to have a PTIN. The Treasury Department and the IRS estimate that approximately 800,000 individuals will apply annually for an initial or renewal PTIN. Although the final regulations will likely affect a substantial number of small entities, the economic impact on those entities is not significant. The final regulations will establish a \$21 fee per application or renewal (plus \$14.95 payable to the contractor), which is a reduction from the previously established fee of \$33 (plus \$17 payable to the contractor) per application or renewal and will not have a significant economic impact on a small entity. Accordingly, the Secretary certifies that the rule will not have a significant economic impact on a substantial number of small entities.

Pursuant to section 7805(f), the notice of proposed rulemaking was submitted to the Chief Counsel for the Office of Advocacy of the Small Business Administration for comment on its impact on small business (85 FR 21126). No comments on the notice were received from the Chief Counsel for the Office of Advocacy of the Small Business Administration.

Drafting Information

The principal author of these regulations is Michael A. Franklin, Office of the Associate Chief Counsel (Procedure and Administration). Other personnel from the Treasury Department and the IRS participated in the development of the regulations.

List of Subjects in 26 CFR Part 300

Reporting and recordkeeping requirements, User fees.

¹ <https://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx>

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 300 is amended as follows:

PART 300 – USER FEES

Paragraph 1. The authority citation for part 300 continues to read as follows:

Authority: 31 U.S.C. 9701.

Par. 2. Section 300.12 is amended by revising paragraphs (b) and (d) to read as follows:

§300.13 Fee for obtaining a preparer tax identification number.

* * * * *

(b) *Fee.* The fee to apply for or renew a preparer tax identification number is \$21 per year and is in addition to the fee charged by the contractor.

* * * * *

(d) *Applicability date.* This section applies to applications for or renewal of a preparer tax identification number filed on or after August 17, 2020.

Sunita Lough,
*Deputy Commissioner for Services
and Enforcement.*

Approved: July 2, 2020.

David J. Kautter,
*Assistant Secretary of the Treasury
(Tax Policy).*

(Filed by the Office of the Federal Register on July 15, 2020, 4:15 p.m., and published in the issue of the Federal Register for July 17, 2020, 85 F.R. 43433)

Part III

Additional Relief with Respect to Deadlines under Section 501(r)(3) Applicable to Hospital Organizations Affected by the Ongoing Coronavirus Disease 2019 Pandemic

Notice 2020-56

SECTION 1. PURPOSE

In response to the ongoing Coronavirus Disease 2019 (COVID-19) pandemic, this notice amplifies the relief provided in Notice 2020-23, 2020-18 IRB 742, for hospital organizations that are required to meet the community health needs assessment (CHNA) requirements under section 501(r)(3) of the Code. Notice 2020-23 postponed until July 15, 2020, the deadline for performing any CHNA requirement that is due to be completed on or after April 1, 2020, and before July 15, 2020. This notice provides a further postponement, until December 31, 2020, of the deadline for performing any CHNA requirement due to be completed on or after April 1, 2020, and before December 31, 2020.

SECTION 2. BACKGROUND

A. CHNA Requirements for Hospital Organizations

Section 501(r)(1) states that an organization described in section 501(r)(2) (a hospital organization) will not be treated as described in section 501(c)(3) unless the organization meets the requirements described in section 501(r)(3) through 501(r)(6). Section 501(r)(2) specifies that a hospital organization must meet the section 501(r) requirements, including the requirements of section 501(r)(3), separately with respect to each hospital facility it operates.

Section 501(r)(3) requires a hospital organization to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through

the CHNA (collectively, CHNA requirements). The CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. In addition, the CHNA must be made widely available to the public.

The CHNA must be conducted by the end of the third taxable year (or in either of the two taxable years immediately preceding such taxable year). The implementation strategy must be adopted on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA.

Section 4959 imposes a \$50,000 excise tax on a hospital organization that fails to meet either or both of the section 501(r)(3) CHNA requirements with respect to any hospital facility for any taxable year.

B. COVID-19 Disaster Relief – Prior Postponement of Certain Deadlines and Other Requirements Pursuant to Section 7508A

On March 13, 2020, the President of the United States issued an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 et seq., in response to the ongoing COVID-19 pandemic (Emergency Declaration). The Emergency Declaration instructed the Secretary of the Treasury “to provide relief from tax deadlines to Americans who have been adversely affected by the COVID-19 emergency, as appropriate, pursuant to 26 U.S.C. 7508A(a).”

Section 7508A provides the Secretary of the Treasury or his delegate (Secretary) with the authority to postpone the time for performing certain acts under the internal revenue laws for a taxpayer determined by the Secretary to be affected by a federally declared disaster as defined in section 165(i)(5)(A). Pursuant to section 7508A(a), a period of up to one year may be disregarded in determining whether the performance of certain acts is timely under the internal revenue laws.

On April 9, 2020, the Department of the Treasury and the Internal Revenue Service issued Notice 2020-23, which

provides relief under section 7508A(a) of the Code for certain persons that the Secretary determined to be affected by the COVID-19 emergency. Notice 2020-23 provides, among other things, that the term Affected Taxpayer includes any person who performs a time-sensitive action listed in Rev. Proc. 2018-58, 2018-50 IRB 990, due to be performed (originally or pursuant to a valid extension) on or after April 1, 2020, and before July 15, 2020. The time-sensitive actions listed in Rev. Proc. 2018-58 include the requirement under section 501(r)(3) to conduct a CHNA in the taxable year or in either of the two taxable years immediately preceding the taxable year and to adopt an implementation strategy to meet the community health needs identified through the CHNA. *See* Rev. Proc. 2018-58, section 10, 2018-50 IRB at 1005. Accordingly, Notice 2020-23 postponed until July 15, 2020, the deadline for any CHNA due to be conducted and for any implementation strategy due to be adopted on or after April 1, 2020, and before July 15, 2020.

SECTION 3. GRANT of RELIEF

Any hospital organization that is required to meet either of the CHNA requirements under section 501(r)(3) of the Code on or after April 1, 2020, and before December 31, 2020 (Specified Time-Sensitive Action), is determined to be affected by the COVID-19 emergency for purposes of the relief described in this section 3 (Affected Taxpayer).

For an Affected Taxpayer, the due date for any CHNA due to be conducted and for any implementation strategy due to be adopted on or after April 1, 2020, and before December 31, 2020, is postponed to December 31, 2020. Even though the due date for a CHNA to be conducted on or after April 1, 2020, and before December 31, 2020, is postponed to December 31, 2020, by this notice, for purposes of applying § 1.501(r)-3(c)(5) of the Income Tax Regulations to determine the deadline for adoption of the implementation strategy, the hospital facility is not considered to have completed the final step for the CHNA in a later taxable year. Thus, for example, if an Affected Taxpayer was required to con-

duct a CHNA by April 30, 2020 (the end of the third taxable year) and was required to adopt an implementation strategy by September 15, 2020, the Affected Taxpayer now has an extension until December 31, 2020, to complete both steps.

SECTION 4. EFFECT ON OTHER DOCUMENTS

Notice 2020-23 is amplified.

SECTION 5. DRAFTING INFORMATION

The principal author of this notice is Ingrid M. Vatamanu of the Office of the Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes). For further information regarding this notice contact Ingrid M. Vatamanu on (202) 317-4541 (not a toll-free number).

Update for Weighted Average Interest Rates, Yield Curves, and Segment Rates

Notice 2020-57

This notice provides guidance on the corporate bond monthly yield curve, the

corresponding spot segment rates used under § 417(e)(3), and the 24-month average segment rates under § 430(h)(2) of the Internal Revenue Code. In addition, this notice provides guidance as to the interest rate on 30-year Treasury securities under § 417(e)(3)(A)(ii)(II) as in effect for plan years beginning before 2008 and the 30-year Treasury weighted average rate under § 431(c)(6)(E)(ii)(I).

YIELD CURVE AND SEGMENT RATES

Section 430 specifies the minimum funding requirements that apply to single-employer plans (except for CSEC plans under § 414(y)) pursuant to § 412. Section 430(h)(2) specifies the interest rates that must be used to determine a plan’s target normal cost and funding target. Under this provision, present value is generally determined using three 24-month average interest rates (“segment rates”), each of which applies to cash flows during specified periods. To the extent provided under § 430(h)(2)(C)(iv), these segment rates are adjusted by the applicable percentage of the 25-year average segment rates for the period ending September 30 of the year preceding the calendar year in which the plan year begins.¹ However, an election may be made under § 430(h)(2)(D)(ii) to use the monthly yield curve in place of the segment rates.

Notice 2007-81, 2007-44 I.R.B. 899, provides guidelines for determining the

monthly corporate bond yield curve, and the 24-month average corporate bond segment rates used to compute the target normal cost and the funding target. Consistent with the methodology specified in Notice 2007-81, the monthly corporate bond yield curve derived from June 2020 data is in Table 2020-6 at the end of this notice. The spot first, second, and third segment rates for the month of June 2020 are, respectively, 0.74, 2.57, and 3.32.

The 24-month average segment rates determined under § 430(h)(2)(C)(i) through (iii) must be adjusted pursuant to § 430(h)(2)(C)(iv) to be within the applicable minimum and maximum percentages of the corresponding 25-year average segment rates. For plan years beginning before 2021, the applicable minimum percentage is 90% and the applicable maximum percentage is 110%. The 25-year average segment rates for plan years beginning in 2019 and 2020 were published in Notice 2018-73, 2018-40 I.R.B. 526, and Notice 2019-51, 2019-41 I.R.B. 866, respectively.

24-MONTH AVERAGE CORPORATE BOND SEGMENT RATES

The three 24-month average corporate bond segment rates applicable for July 2020 without adjustment for the 25-year average segment rate limits are as follows:

24-Month Average Segment Rates Without 25-Year Average Adjustment			
Applicable Month	First Segment	Second Segment	Third Segment
July 2020	2.44	3.54	4.04

Based on § 430(h)(2)(C)(iv), the 24-month averages applicable for July 2020, adjusted to be within the applicable minimum and maximum percentages of the corresponding 25-year average segment rates, are as follows:

Adjusted 24-Month Average Segment Rates				
For Plan Years Beginning In	Applicable Month	First Segment	Second Segment	Third Segment
2019	July 2020	3.74	5.35	6.11
2020	July 2020	3.64	5.21	5.94

¹ Pursuant to § 433(h)(3)(A), the 3rd segment rate determined under § 430(h)(2)(C) is used to determine the current liability of a CSEC plan (which is used to calculate the minimum amount of the full funding limitation under § 433(c)(7)(C)).

30-YEAR TREASURY SECURITIES INTEREST RATES

Section 431 specifies the minimum funding requirements that apply to multi-employer plans pursuant to § 412. Section 431(c)(6)(B) specifies a minimum amount for the full-funding limitation described in § 431(c)(6)(A), based on the plan's current liability. Section 431(c)(6)(E)(ii)(I) pro-

vides that the interest rate used to calculate current liability for this purpose must be no more than 5 percent above and no more than 10 percent below the weighted average of the rates of interest on 30-year Treasury securities during the four-year period ending on the last day before the beginning of the plan year. Notice 88-73, 1988-2 C.B. 383, provides guidelines for determining the weighted average interest rate. The rate

of interest on 30-year Treasury securities for June 2020 is 1.49 percent. The Service determined this rate as the average of the daily determinations of yield on the 30-year Treasury bond maturing in May 2050. For plan years beginning in July 2020, the weighted average of the rates of interest on 30-year Treasury securities and the permissible range of rates used to calculate current liability are as follows:

<i>Treasury Weighted Average Rates</i>		
For Plan Years Beginning In	30-Year Treasury Weighted Average	Permissible Range 90% to 105%
July 2020	2.55	2.30 to 2.68

MINIMUM PRESENT VALUE SEGMENT RATES

In general, the applicable interest rates

under § 417(e)(3)(D) are segment rates computed without regard to a 24-month average. Notice 2007-81 provides guidelines for determining the minimum pres-

ent value segment rates. Pursuant to that notice, the minimum present value segment rates determined for June 2020 are as follows:

<i>Minimum Present Value Segment Rates</i>			
Month	First Segment	Second Segment	Third Segment
June 2020	0.74	2.57	3.32

DRAFTING INFORMATION

The principal author of this notice is Tom Morgan of the Office of the Asso-

ciate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes). However, other personnel from the IRS participated in the development

of this guidance. For further information regarding this notice, contact Mr. Morgan at 202-317-6700 or Paul Stern at 202-317-8702 (not toll-free numbers).

Table 2020-6
Monthly Yield Curve for June 2020
Derived from June 2020 Data

<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>
0.5	0.36	20.5	3.19	40.5	3.34	60.5	3.40	80.5	3.43
1.0	0.49	21.0	3.20	41.0	3.34	61.0	3.40	81.0	3.43
1.5	0.60	21.5	3.20	41.5	3.34	61.5	3.40	81.5	3.43
2.0	0.69	22.0	3.21	42.0	3.34	62.0	3.40	82.0	3.43
2.5	0.74	22.5	3.21	42.5	3.35	62.5	3.40	82.5	3.43
3.0	0.79	23.0	3.22	43.0	3.35	63.0	3.40	83.0	3.43
3.5	0.83	23.5	3.22	43.5	3.35	63.5	3.40	83.5	3.43
4.0	0.89	24.0	3.22	44.0	3.35	64.0	3.40	84.0	3.43
4.5	0.97	24.5	3.23	44.5	3.35	64.5	3.40	84.5	3.43
5.0	1.06	25.0	3.23	45.0	3.36	65.0	3.41	85.0	3.43
5.5	1.17	25.5	3.24	45.5	3.36	65.5	3.41	85.5	3.43
6.0	1.30	26.0	3.24	46.0	3.36	66.0	3.41	86.0	3.43
6.5	1.43	26.5	3.24	46.5	3.36	66.5	3.41	86.5	3.43
7.0	1.58	27.0	3.25	47.0	3.36	67.0	3.41	87.0	3.43
7.5	1.72	27.5	3.25	47.5	3.36	67.5	3.41	87.5	3.43
8.0	1.86	28.0	3.26	48.0	3.37	68.0	3.41	88.0	3.44
8.5	2.00	28.5	3.26	48.5	3.37	68.5	3.41	88.5	3.44
9.0	2.13	29.0	3.27	49.0	3.37	69.0	3.41	89.0	3.44
9.5	2.25	29.5	3.27	49.5	3.37	69.5	3.41	89.5	3.44
10.0	2.36	30.0	3.27	50.0	3.37	70.0	3.41	90.0	3.44
10.5	2.47	30.5	3.28	50.5	3.37	70.5	3.41	90.5	3.44
11.0	2.57	31.0	3.28	51.0	3.37	71.0	3.42	91.0	3.44
11.5	2.65	31.5	3.29	51.5	3.38	71.5	3.42	91.5	3.44
12.0	2.73	32.0	3.29	52.0	3.38	72.0	3.42	92.0	3.44
12.5	2.80	32.5	3.29	52.5	3.38	72.5	3.42	92.5	3.44
13.0	2.86	33.0	3.30	53.0	3.38	73.0	3.42	93.0	3.44
13.5	2.91	33.5	3.30	53.5	3.38	73.5	3.42	93.5	3.44
14.0	2.96	34.0	3.30	54.0	3.38	74.0	3.42	94.0	3.44
14.5	3.00	34.5	3.31	54.5	3.38	74.5	3.42	94.5	3.44
15.0	3.03	35.0	3.31	55.0	3.39	75.0	3.42	95.0	3.44
15.5	3.06	35.5	3.31	55.5	3.39	75.5	3.42	95.5	3.44
16.0	3.08	36.0	3.31	56.0	3.39	76.0	3.42	96.0	3.44
16.5	3.10	36.5	3.32	56.5	3.39	76.5	3.42	96.5	3.44
17.0	3.12	37.0	3.32	57.0	3.39	77.0	3.42	97.0	3.44
17.5	3.14	37.5	3.32	57.5	3.39	77.5	3.42	97.5	3.44
18.0	3.15	38.0	3.33	58.0	3.39	78.0	3.42	98.0	3.44
18.5	3.16	38.5	3.33	58.5	3.39	78.5	3.43	98.5	3.44
19.0	3.17	39.0	3.33	59.0	3.39	79.0	3.43	99.0	3.44
19.5	3.18	39.5	3.33	59.5	3.40	79.5	3.43	99.5	3.44
20.0	3.18	40.0	3.34	60.0	3.40	80.0	3.43	100.0	3.45

26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.
(Also §§ 36B, 1.36B-2, 1.36B-3.)

Rev. Proc. 2020-36

SECTION 1. PURPOSE

This revenue procedure provides indexing adjustments for certain provisions under § 36B of the Internal Revenue Code. In particular, it updates the applicable percentage table in § 36B(b)(3)(A)(i) (Applicable Percentage Table) for calendar year 2021. This table is used to calculate an individual's premium tax credit. The revenue procedure also updates the required contribution percentage in § 36B(c)(2)(C)(i)(II) for plan years be-

ginning after calendar year 2020 (Section 36B Required Contribution Percentage). This percentage is used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage under § 36B. The revenue procedure uses the methodology described in Section 4 of Rev. Proc. 2014-37, 2014-2 C.B. 363, and the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 17454 (April 25, 2019) (2020 Benefit and Payment Notice), to index the Applicable Percentage Table and the Section 36B Required Contribution Percentage.

In addition to the adjustments described in Rev. Proc. 2014-37 for adjusting the Applicable Percentage Table, § 36B(b)(3)(A)(ii)(II) provides that, except as provid-

ed in § 36B(b)(3)(A)(ii)(III), an additional adjustment must be made for calendar years after 2018 to reflect the rates of premium growth relative to the growth in the consumer price index. The Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) have determined that the failsafe exception described in § 36B(b)(3)(A)(ii)(III) applies for calendar year 2021 and no additional adjustment under § 36B(b)(3)(A)(ii)(II) is required for calendar year 2021.

SECTION 2. ADJUSTED ITEMS

.01 *Applicable Percentage Table for 2021.* For taxable years beginning in calendar year 2021, the Applicable Percentage Table for purposes of § 36B(b)(3)(A)(i) and § 1.36B-3(g) is:

Household income percentage of Federal poverty line:	Initial percentage	Final percentage
Less than 133%	2.07%	2.07%
At least 133% but less than 150%	3.10%	4.14%
At least 150% but less than 200%	4.14%	6.52%
At least 200% but less than 250%	6.52%	8.33%
At least 250% but less than 300%	8.33%	9.83%
At least 300% but not more than 400%	9.83%	9.83%

.02 *Section 36B Required Contribution Percentage for 2021.* For plan years beginning in calendar year 2021, the required contribution percentage for purposes of § 36B(c)(2)(C)(i)(II) and § 1.36B-2(c)(3)(v)(C) is 9.83%.

SECTION 3. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2014-37 is supplemented.

SECTION 4. EFFECTIVE DATE

This revenue procedure is effective for taxable years and plan years beginning after December 31, 2020.

SECTION 5. DRAFTING INFORMATION

The principal author of this revenue procedure is Bill Ruane of the Office of Associate Chief Counsel (Income Tax and Accounting). For further information regarding this revenue procedure, contact Mr. Ruane at (202) 317-4718 (not a toll-free number).

Part IV

Announcement 2020-8

Correction to Revenue Procedure 2020-35, IRB 2015-29

SUMMARY: This document contains corrections to Revenue Procedure 2020-35, published in **Internal Revenue Bulletin 2020-29** on Monday, July 13, 2020. The purpose of this revenue procedure is to set forth the 2020 requirements for using official Internal Revenue Service (IRS) forms to file information returns with the IRS, preparing acceptable substitutes of the official IRS forms to file information returns with the IRS, and using official or acceptable substitute forms to furnish information to recipients.

Need for Correction

As published, the revenue procedure contains the following errors that are in need of correction.

1. In **Section 2.1.1, Online Fillable Forms**, under the heading **Specifications**. The error consists in including in the first paragraph Form 1099-NEC. Form 1099-NEC should be deleted from the paragraph.
2. In **Section 4.5.3, Perforations**, under the heading **Miscellaneous Instructions for Copies B, C, D, E, 1, and 2**. The error consists in indicating that instructions for perforation can be found in Section 2.1.8. The instructions for perforation can be found in Section 2.1.9.

Announcement of Disciplinary Sanctions From the Office of Professional Responsibility

Announcement 2020-9

The Office of Professional Responsibility (OPR) announces recent disci-

plinary sanctions involving attorneys, certified public accountants, enrolled agents, enrolled actuaries, enrolled retirement plan agents, appraisers, and unenrolled/unlicensed return preparers (individuals who are not enrolled to practice and are not licensed as attorneys or certified public accountants). Licensed or enrolled practitioners are subject to the regulations governing practice before the Internal Revenue Service (IRS), which are set out in Title 31, Code of Federal Regulations, Subtitle A, Part 10, and which are released as Treasury Department Circular No. 230. The regulations prescribe the duties and restrictions relating to such practice and prescribe the disciplinary sanctions for violating the regulations. Unenrolled/unlicensed return preparers are subject to Revenue Procedure 81-38 and superseding guidance in Revenue Procedure 2014-42, which govern a preparer's eligibility to represent taxpayers before the IRS in examinations of tax returns the preparer both prepared for the taxpayer **and** signed as the preparer. Additionally, unenrolled/unlicensed return preparers who voluntarily participate in the Annual Filing Season Program under Revenue Procedure 2014-42 agree to be subject to the duties and restrictions in Circular 230, including the restrictions on incompetent or disreputable conduct.

The disciplinary sanctions to be imposed for violation of the applicable standards are:

Disbarred from practice before the IRS—An individual who is disbarred is not eligible to practice before the IRS as defined at 31 C.F.R. § 10.2(a)(4) for a minimum period of five (5) years.

Suspended from practice before the IRS—An individual who is suspended is not eligible to practice before the IRS as defined at 31 C.F.R. § 10.2(a)(4) during the term of the suspension.

Censured in practice before the IRS—Censure is a public reprimand. Unlike disbarment or suspension, censure does not affect an individual's eligibility to practice before the IRS, but OPR may subject the individual's future practice rights to conditions designed to promote high standards of conduct.

Monetary penalty—A monetary penalty may be imposed on an individual who engages in conduct subject to sanction, or on an employer, firm, or entity if the individual was acting on its behalf and it knew, or reasonably should have known, of the individual's conduct.

Disqualification of appraiser—An appraiser who is disqualified is barred from presenting evidence or testimony in any administrative proceeding before the Department of the Treasury or the IRS.

Ineligible for limited practice—An unenrolled/unlicensed return preparer who fails to comply with the requirements in Revenue Procedure 81-38 or to comply with Circular 230 as required by Revenue Procedure 2014-42 may be determined ineligible to engage in limited practice as a representative of any taxpayer.

Under the regulations, individuals subject to Circular 230 may not assist, or accept assistance from, individuals who are suspended or disbarred with respect to matters constituting practice (*i.e.*, representation) before the IRS, and they may not aid or abet suspended or disbarred individuals to practice before the IRS.

Disciplinary sanctions are described in these terms:

Disbarred by decision, Suspended by decision, Censured by decision, Monetary penalty imposed by decision, and Disqualified after hearing—An administrative law judge (ALJ) issued a decision imposing one of these sanctions after the ALJ either (1) granted the government's summary judgment motion or (2) conducted an evidentiary hearing upon OPR's complaint alleging violation of the regulations. After 30 days from the issuance of the decision, in the absence of an appeal, the ALJ's decision becomes the final agency decision.

Disbarred by default decision, Suspended by default decision, Censured by default decision, Monetary penalty imposed by default decision, and Disqualified by default decision—An ALJ, after finding that no answer to OPR's complaint was filed, granted OPR's motion for a default judgment and issued a decision imposing one of these sanctions.

Disbarment by decision on appeal, Suspended by decision on appeal, Censured by decision on appeal, Monetary penalty imposed by decision on appeal, and Disqualified by decision on appeal—The decision of the ALJ was appealed to the agency appeal authority, acting as the delegate of the Secretary of the Treasury, and the appeal authority issued a decision imposing one of these sanctions.

Disbarred by consent, Suspended by consent, Censured by consent, Monetary penalty imposed by consent, and Disqualified by consent—In lieu of a disciplinary proceeding being instituted or continued, an individual offered a consent to one of these sanctions and OPR accepted the offer. Typically, an offer of consent will provide for: suspension for an indefinite term; conditions that the individual must observe during the suspension; and the individual's opportunity, after a stated number of months, to file with OPR a petition for reinstatement affirming compliance with the terms of the consent and affirming current fitness and eligibility to practice (*i.e.*, an active professional license or active enrollment status, with no intervening violations of the regulations).

Suspended indefinitely by decision in expedited proceeding, Suspended indefinitely by default decision in expedited proceeding, Suspended by consent in expedited proceeding—OPR instituted an expedited proceeding for suspension

(based on certain limited grounds, including loss of a professional license for cause, and criminal convictions).

Determined ineligible for limited practice—There has been a final determination that an unenrolled/unlicensed return preparer is not eligible for limited representation of any taxpayer because the preparer violated standards of conduct or failed to comply with any of the requirements to act as a representative.

A practitioner who has been disbarred or suspended under 31 C.F.R. § 10.60, or suspended under § 10.82, or a disqualified appraiser may petition for reinstatement before the IRS after the expiration of 5 years following such disbarment, suspension, or disqualification (or immediately following the expiration of the suspension or disqualification period if shorter than 5 years). Reinstatement will not be granted unless the IRS is satisfied that the petitioner is not likely to engage thereafter in conduct contrary to Circular 230, and that granting such reinstatement would not be contrary to the public interest.

Reinstatement decisions are published at the individual's request, and described in these terms:

Reinstated to practice before the IRS—The individual's petition for reinstatement has been granted. The agent, and eligible to practice before the IRS, or in the case of an appraiser, the individual is no longer disqualified.

Reinstated to engage in limited practice before the IRS—The individual's petition for reinstatement has been granted. The individual is an unenrolled/unlicensed return preparer and eligible to engage in limited practice before the IRS, subject to requirements the IRS has prescribed for limited practice by tax return preparers.

OPR has authority to disclose the grounds for disciplinary sanctions in these situations: (1) an ALJ or the Secretary's delegate on appeal has issued a final decision; (2) the individual has settled a disciplinary case by signing OPR's "consent to sanction" agreement admitting to one or more violations of the regulations and consenting to the disclosure of the admitted violations (for example, failure to file Federal income tax returns, lack of due diligence, conflict of interest, etc.); (3) OPR has issued a decision in an expedited proceeding for indefinite suspension; or (4) OPR has made a final determination (including any decision on appeal) that an unenrolled/unlicensed return preparer is ineligible to represent any taxpayer before the IRS.

Announcements of disciplinary sanctions appear in the Internal Revenue Bulletin at the earliest practicable date. The sanctions announced below are alphabetized first by state and second by the last names of the sanctioned individuals.

City & State	Name	Professional Designation	Disciplinary Sanction	Effective Date(s)
Florida				
Stuart	Koplas, Michael R.	CPA	Suspended by consent for admitted violations of 31 C.F.R. §§ 10.51(a)(6) and (a)(17)	Indefinite from April 20, 2020
New Jersey				
Morris Plains	Fraser, Carlyle	CPA		Reinstated to practice before the IRS, effective March 23, 2020

City & State	Name	Professional Designation	Disciplinary Sanction	Effective Date(s)
New Mexico				
Albuquerque	Vaughn, James A.	CPA		Reinstated to practice before the IRS, effective April 15, 2020
Pennsylvania				
Lower Gwynedd	Vance, Dean	CPA	Disbarred by Consent under 31 C.F.R. § 10.51(a)(6)	Indefinite from August 27, 2018
South Carolina				
Charleston	Molony, John W.	CPA	Disbarred by ALJ	Indefinite from May 24, 2020
Wisconsin				
Hales Corners	Neal, Jon C.	CPA		Reinstated to practice before the IRS, effective April 27, 2020

Notice of Proposed Rulemaking

Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage

REG-130081-19

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: Notice of proposed rulemaking.

SUMMARY: This document is a notice of proposed rulemaking regarding grandfathered group health plans and grandfathered group health insurance coverage 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.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 14, 2020.

ADDRESSES: Written comments may be submitted to the addresses specified below. Any comment that is submitted will be shared among the Departments. Please do not submit duplicates.

All comments will be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the internet exactly as received and can be retrieved by most internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

In commenting, refer to file code RIN 1210-AB89. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.

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

Office of Health Plan Standards and Compliance Assistance

Employee Benefits Security Administration

US Department of Labor

Attention: RIN 1210-AB89

200 Constitution Avenue NW, Room N-5653

Washington, DC 20210

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

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

Office of Health Plan Standards and Compliance Assistance

Employee Benefits Security Administration

US Department of Labor

Attention: RIN 1210-AB89
200 Constitution Avenue NW, Room
N-5653
Washington, DC 20210

For information on viewing public comments, see the beginning of the “SUPPLEMENTARY INFORMATION” section.

FOR FURTHER INFORMATION CONTACT:

William Fischer, Internal Revenue Service, Department of the Treasury, at (202) 317-5500.

David Sydlik or Frank Kolb, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335.

Cam Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492-4400.

Customer Service Information:

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

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. Comments received before the close of the comment period are posted on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments.

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.”

The Departments of Health and Human Services (HHS), Labor, and 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 sta-

tus, 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 are issuing this notice of proposed rulemaking 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. In the Departments’ view, these proposed amendments are appropriate because they would enable these plans to continue offering affordable coverage while also enhancing their ability to respond to rising healthcare costs. In some cases, the proposed 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).

These proposed rules would only address the requirements for grandfathered group health plans and grandfathered group health insurance coverage, and would 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 insurance coverage has declined each year since PPACA was enacted. As one commenter noted, this decline in enrollment in grandfathered individual health insurance coverage will continue due to the natural churn that occurs, because most consumers stay in the individual market for less than five years.² Compared to the number of individuals in grandfathered group health plans and group health insurance cover-

¹ 84 FR 5969 (Feb. 25, 2019).

² The cause of this churn varies. For example, beginning a new job that offers group health insurance coverage may result in the natural transition from the individual market to the group market. Eligibility for Medicaid or Medicare can also result in a consumer leaving the individual market.

age, only a small number of individuals are enrolled in grandfathered individual health insurance coverage.³ 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 subject to certain, but not all, provisions of PPACA for as long as they maintain their status as grandfathered health plans.⁴ 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.⁵ 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.⁶ 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.⁷ After consideration of the 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).⁸

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

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 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.

The 2015 final rules specify when 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 co-insurance);
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 by more than five percentage points below the contribution 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

³ 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.

⁴ 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 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>.

⁵ 75 FR 34538 (June 17, 2010).

⁶ 75 FR 70114 (Nov. 17, 2010).

⁷ 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.

⁸ 80 FR 72192 (Nov. 18, 2015), codified at 26 CFR 54.9815-1251, 29 CFR 2590.715-1251, and 45 CFR 147.140.

the cost of the healthcare benefit subject to the coinsurance obligation increases, so changes to the 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) could significantly alter the financial obligation of consumers 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. 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 or (2) five dollars increased by medical inflation. 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 Department of Labor using the 1982–1984 base of 100.

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 include a statement in any summary of benefits provided under the plan that it believes the plan or coverage is a grandfathered health plan, as well as 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 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. 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. Accordingly, on February 25, 2019, the Departments published in the Federal Register the 2019 RFI⁹ 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.

Comments submitted in response to the 2019 RFI provided information regarding grandfathered health plans that has informed these 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 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 are in existence and suggested that very large employers with self-funded plans may have 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

⁹ 84 FR 5969 (Feb. 25, 2019), available at <https://www.federalregister.gov/documents/2019/02/25/2019-03170/request-for-information-regarding-grandfathered-group-health-plans-and-grandfathered-group-health>.

¹⁰ On September 25, 2019, the Kaiser Family Foundation issued its 2019 report, which showed little change since 2018 with respect to grandfathered plans. According to survey data, 22 percent of offering firms report having at least one grandfathered plan in 2019, and 13 percent of covered workers were enrolled in a grandfathered health plan in 2019. See *2019 Employer Health Benefits Survey*, Kaiser Family Foundation, available at <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/>. See also *2018 Employer Health Benefits Survey*, Kaiser Family Foundation, available at <https://www.kff.org/report-section/2018-employer-healthbenefits-survey-section-13-grandfathered-healthplans/>.

incorrectly in surveys that they still have 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 any greater flexibility for a plan or coverage to maintain grandfather status. Other commenters noted, however, that grandfathered 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 argued 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 they have found that their grandfathered plans offer more robust provider networks than other coverage options that are available to them or that they want to ensure 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 on how the 2015 final rules should be amended. 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, arguing 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 af-

fected. 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 and the difficulty issuers face in gathering necessary information from employers to know that their contribution rates have not decreased.

Commenters also suggested amendments relating to the permitted changes in cost-sharing requirements for grandfathered health 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 Internal Revenue Code (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 Code section 5000A (defined at 45 CFR 155.605(d)(2)); and (3) the employer shared responsibility payment amounts under Code section 4980H(a) and (b) (see Code section 4980H(c)(5)). 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 in the annual HHS notice of benefit and payment parameters.

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, at the time of proposal in the annual HHS notice of benefit and payment parameters proposed rule, National Health Expenditure Accounts (NHEA) projection of per enrollee premiums for private health insurance, excluding Medigap and

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, would send a notice to all individuals and small businesses that received or would otherwise receive a cancellation or termination notice with respect to the coverage, and the coverage would not be treated as being out of compliance with certain specified market reforms. CMS has extended this non-enforcement policy each 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>.

property and casualty insurance, for 2013 and the preceding calendar year.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 providing tax benefits to pay for qualified medical expenses on behalf of the account beneficiary, his or her spouse, and any dependents claimed. Among the requirements 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) is the requirement that the individual 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 CPI-U.

II. Overview of Proposed Rules

A. Introduction

This notice of proposed rulemaking 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, and therefore these proposed rules would not provide any oppor-

tunity for a plan or coverage that has lost its grandfather status under the 2015 final rules to regain that status.

In issuing these proposed rules, the Departments considered comments submitted in response to the 2019 RFI regarding ways that the 2015 final rules should be amended. Many suggestions outlined in the comments are not being proposed here because, in the Departments' view, they would allow for such significant changes that the modified plan or coverage could not reasonably be described as being the same plan or coverage that was offered on March 23, 2010, for purposes of grandfather status. However, the commenters' arguments 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 were persuasive. The Departments also agree that, as one commenter highlighted, there is an opportunity to clarify 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 are of the view that these suggestions are 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, these proposed rules would amend the 2015 final rules in two ways. First, these proposed rules include a new paragraph (g)(3) which would specify 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) of the Code. Second, these proposed rules include a revised definition of "maximum percentage increase" in redesignated paragraph (g) (4), which provides an alternative method of determining that amount based on the premium adjustment percentage. 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 effective date of a final rule.

The Departments request comments on all aspects of these proposed rules. In the preamble discussion that follows, the Departments also solicit comments on specific issues related to the proposed rules where stakeholder feedback would be particularly useful in evaluating whether and how to issue final rules.

B. 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. These amounts are updated annually to reflect a cost-of-living adjustment and are published each year by the Internal Revenue Service.

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.¹³ Nevertheless, the Departments are of the view

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 web site, 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 For calendar year 2020, a "high deductible health plan" is defined under Code § 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. For calendar year 2021, a "high deductible health plan" is defined under Code § 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.

that there is value in providing assurance to grandfathered plans 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), such an increase would not cause the plan or coverage to relinquish its grandfather status. Otherwise, if such a conflict were to occur, the sponsor of the plan would have to decide whether to preserve the plan's grandfather status or its status as an HDHP. This would mean participants and beneficiaries would 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, these proposed rules include a new paragraph (g)(3), which provides 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.¹⁴ 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. These proposed rules would also add a new example 11 under paragraph (g)(5) to illustrate how this special rule would apply.

C. Definition of Maximum Percentage Increase

The Departments agree with stakeholders who submitted comments on the 2019 RFI stating that the premium adjust-

ment percentage (as defined at 45 CFR 156.130(e) and published for each year by HHS in the annual notice of benefit and payment parameters) may be a more appropriate measurement of changes in healthcare costs over time than medical inflation, as defined in the 2015 final rules.

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 Department of Labor 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 believe 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 agree with comments that the premium adjustment percentage better reflects the increase in underlying costs for grandfathered group health plans and grandfathered group health insurance coverage. The Departments acknowledge that the premium adjustment percentage does not capture premium growth from 2010 to 2013, and that it reflects increases in premiums in the individual market, which have increased more rapidly than premiums for group health plans and group health insurance. However, the Departments believe the premium adjustment percentage is the best existing measure to reflect the increase in underlying costs for grandfathered group health plans and grandfathered group health insurance

coverage. Additionally, the Departments believe using a measure with which plans and issuers are already familiar would increase administrative simplicity. Nevertheless, the Departments seek comment on alternative measures that more accurately represent the increase in underlying costs for grandfathered group health plans and grandfathered group health insurance coverage.

These proposed rules include an amended definition of the maximum percentage increase that provides 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 Consumer Price Index for All Urban Consumers, unadjusted), to account for changes in healthcare costs over time. This alternative standard would not supplant the current standard; rather, it would be available to the extent it yields a greater result 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 effective date of the final rule. With respect to increases for group health plans and group health insurance coverage made effective on or after March 23, 2010, and before the effective date of the final rule, the maximum percentage increase would still be defined as medical inflation expressed as a percentage, plus 15 percentage points.¹⁵

Thus, under these proposed rules, increases to fixed-amount cost-sharing requirements for grandfathered group health plans and grandfathered group health insurance coverage that are made effective on or after the effective date of the final rule, 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, 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),

¹⁴ Paragraph (g)(3) of the 2015 final rules would be renumbered as paragraph (g)(4), and subsequent paragraphs would be renumbered accordingly. Additionally, the proposed rules include conforming amendments to other paragraphs in the proposed rules to update all cross-references to those subparagraphs.

¹⁵ The amendments included in these 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 regulations would also add a separate provision for individual health insurance coverage to show that the applicable definition remains unchanged.

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. These proposed rules would also add 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 new example 5 includes 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. These proposed rules would also renumber examples 5-9 in paragraph (g)(5) to allow the inclusion of new example 5 and to revise examples 3-6 to clarify that these examples involve plan changes that become effective before the effective date of the final rule. These proposed revisions would ensure that the examples accurately reflect the other provisions of the rule.

Stakeholders reviewing these proposed rules 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.

III. Effective Date

The amendments to the 2015 final rules that are included in these proposed rules would apply to grandfathered group health plans and grandfathered group health insurance coverage beginning 30 days after the publication of any final rules. The Departments solicit comment on this proposed effective date.

IV. Economic Impact Analysis and Paperwork Burden

A. Summary/Statement of Need

Section 1251 of PPACA 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 suggest that issuers and plan sponsors, as well as participants and beneficiaries, continue to value the option to continue grandfathered group health plan and grandfathered group health insurance coverage. The Departments are of the view that these proposed rules would be appropriate to provide certain grandfathered health plans greater flexibility to make changes to certain types of cost-sharing requirements without causing a loss of grandfather status. These changes would 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 these proposed rules, the Departments attempted to balance a number of competing interests. For example, the Departments sought to balance providing greater flexibility to grandfathered group health plans and grandfathered group health insurance coverage that would enable these plans and coverage to continue offering quality, affordable coverage to participants and beneficiaries against ensuring that the proposed policies would 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 plans to make unfettered changes while retaining grandfather status would be inconsistent with Congress's intent in enacting PPACA.¹⁶

These proposed rules, if finalized, would 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 proposed rules would 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) of the Code. Second, these proposed rules would include a revised definition of "maximum percentage increase," which provides an alternative method of determining that amount that is based on the premium adjustment percentage.

B. Overall Impact

The Departments have examined the impacts of these proposed 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 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104-

¹⁶ 75 FR 34538, 34546 (June 17, 2010).

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 must be prepared for rules with economically significant effects (\$100 million or more in any one 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 one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3)

materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. A regulatory impact analysis 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. As discussed below regarding their anticipated effects, these proposals are not likely to have economic impacts of \$100 million or more in any one year, and therefore do not meet the definition of “economically significant” under Executive Order 12866. OMB has determined, however, that the actions are significant within the meaning of section 3(f)(4) of the Executive Order. Therefore, OMB has reviewed these proposed rules and the Departments have provided the following assessment of their impact.

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

These proposed rules, if finalized, would 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 proposed rules would 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) of the Code. The proposed rules would also revise the definition of “maximum percentage increase” to provide an alternative method of determining that amount that is based on the premium adjustment percentage. 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 these proposed rules. The effects in Table 1 reflect non-quantified impacts and estimated direct monetary costs and transfers resulting from the provisions of these proposed rules for plans, issuers, participants, and beneficiaries.

TABLE 1: Accounting Table

Benefits				
Non-Quantified:				
<ul style="list-style-type: none"> Allows sponsors of grandfathered group health plans and grandfathered group health insurance coverage more flexibility to make changes to certain fixed-amount cost-sharing requirements without losing grandfather status. 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. 				
Costs:	Primary Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$7.95 million	2020	7 percent	2021-2025
	\$7.40 million	2020	3 percent	2021-2025
Quantitative:				
<ul style="list-style-type: none"> Regulatory review costs of \$34.9 million, incurred in 2020 only, by grandfathered group health plan coverage sponsors and issuers. 				

<p>Non-Quantified:</p> <ul style="list-style-type: none"> • Potential increase in adverse health outcomes if a participant or beneficiary would forego 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 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 PPACA.
Transfers
<p>Non-Quantified:</p> <ul style="list-style-type: none"> • In 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.

These proposed rules propose a new paragraph (g)(3) which would specify that grandfathered group health plans and grandfathered group health insurance coverage that are HDHPs may increase fixed-amount cost-sharing requirements that otherwise would cause a loss of grandfather status, without causing the plan or coverage to relinquish its grandfather status, but only to the extent the increases are necessary to comply with the requirements for HDHPs under section

223(c)(2) of the Code. Additionally, the proposed rules propose a revised definition of “maximum percentage increase” in redesignated paragraph (g)(4) to provide an alternative method of determining that amount that is based on the premium adjustment percentage.

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

The Departments estimate that there are 2.4 million ERISA-covered plans offered by private employers that cover an estimated 134.7 million participants and beneficiaries in those private employer-sponsored plans.¹⁷ Similarly, the Departments estimate that there are 83,500 state and local governments that offer health coverage to their employees, with an estimated 42.8 million participants and beneficiaries in those employer-sponsored plans.¹⁸

The 2019 Employer Health Benefits Survey reports that 22 percent of firms offering health benefits have at least one health plan or benefit package option that is a grandfathered plan, and 13 percent of covered workers are enrolled in grandfathered plans.¹⁹ Using the above information, the Departments estimate that, of those firms offering health benefits, 527,000 sponsor ERISA-covered plans (2.4 million * 0.22) that are grandfathered (or include a grandfathered benefit package option) and cover 17.5 million participants and beneficiaries (134.7 million * 0.13). The Departments further estimate there are 18,400 state and local governments (83,500 * 0.22) offering at least one grandfathered health plan and 5.6 million participants and beneficiaries (42.8 million * 0.13) covered by a grandfathered state or local government plan.

Although the 2019 Employer Health Benefits Survey reports that 26 percent of firms offering health benefits offered an

¹⁷ The Department of Labor estimates based on the 2018 Medical Expenditure Panel Survey Insurance Component (MEPS-IC), available at https://meps.ahrq.gov/data_stats/summ_tables/instr/national/series_1/2018/ic18_ia_g.pdf; Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2016 Annual Social and Economic Supplement to the Current Population Survey, Table 3C, available at <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf>.

¹⁸ 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 2016 Annual Social and Economic Supplement to the Current Population Survey, Table 3C, available at <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf>.

¹⁹ 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 regulatory impact analysis, the Departments used more recent data from the same survey. See Kaiser Family Foundation, “2019 Employer Health Benefits Survey,” available at <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/>.

HDHP and 23 percent of covered workers were enrolled in HDHPs, the Departments believe 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 reports that 12 percent of firms offering health benefits offered an HDHP, and 6 percent of covered workers were enrolled in HDHPs.²⁰

Benefits

The Departments believe that the economic effects of these proposed rules would ultimately depend on any 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, would continue to be more or less favorable than the plan, under the rules applicable to non-grandfathered group health plans. This determination would depend on such factors as the respective prices of grandfathered and non-grandfathered health plans, the willingness of grandfathered group health plans' covered populations to pay for benefits and protections available under non-grandfathered health plans, and their willingness to accept any increases in out-of-pocket costs due to changes to certain types of cost-sharing requirements. The Departments are of the view that providing the proposed 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 would enable plan sponsors and issuers to continue to offer quality, affordable coverage to their participants and beneficiaries while taking into account rising health care costs.

The Departments anticipate that the premium adjustment percentage index will continue to experience faster growth than medical CPI-U, and therefore believe that providing the proposed alternative method of determining the "maximum percentage increase" would, 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 believe that these proposed rules would allow sponsors of those grandfathered health plans to continue to provide the coverage with which their participants and beneficiaries are familiar and comfortable, without the unnecessary burden of finding other coverage.

As noted previously in the preamble, 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 agree that providing the proposed flexibilities could 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 the 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 grandfathered group health plans and 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) of the Code. To reduce the likelihood of this potential scenario, these proposed rules would 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) of the Code.

The Departments are of the view 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), which are used to adjust the HDHP minimum deductible. Using ten 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 CPI-U as required under section 223(g) of the Code. Therefore, the Departments note that, to the extent these trends continue, it is unlikely that

²⁰ Kaiser Family Foundation, "2010 Employer Health Benefits Survey." Available at: <https://www.kff.org/wp-content/uploads/2013/04/8085.pdf>.

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 these proposed rules would 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 these proposed rules. Nevertheless, the Departments are of the view that affording this flexibility would make the rules more transparent to sponsors of grandfathered HDHPs. Thus, the proposed regulations would 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 may be costs associated with these proposed 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 or covered by non-grandfathered group health plans and group health insurance coverage subject to PPACA. It is possible these increased costs could be (partially) offset by lower premiums from participation in the grandfathered plans. Further, participants and beneficiaries who would otherwise be covered by a non-grandfathered plan could potentially face increases in adverse health outcomes if they chose to forego treatment because certain services are not covered by their grandfathered group plan or grandfa-

thered group health insurance coverage. The Departments cannot accurately predict the number of grandfathered health plans and group health insurance coverage that would retain their grandfather status should they choose to avail themselves of the flexibilities provided in these proposed rules. The 2019 Employer Health Benefits Survey reports no significant change from 2018 in the number of firms offering at least one grandfathered health plan or the number of covered individuals.²¹ A large change would have indicated that the current rules were too restrictive and that a relaxation of those rules would have a big effect. The actual small change suggests the opposite. Therefore, the Departments do not expect a significant impact on the number of grandfathered plans or group health insurance coverage as a result of these proposed rules.

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

The Departments recognize there would be transfers associated with these proposed 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 these proposed rules, some participants and beneficiaries of grandfathered group health plans and grandfathered group health insurance coverage could 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 would be permitted under paragraph (g)(1). Changes in costs associated with increased deductibles or other cost sharing would be a transfer from participants and beneficiaries with high out-of-pocket costs to participants and beneficiaries with low 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 plan sponsors would choose to do, the Departments are unable to accurately determine the overall economic impact, but the Departments anticipate that the overall impact would be minimal. However, there is a large degree of uncertainty regarding the effect of the proposed rules on any potential changes to cost sharing at the plan level so actual experience could differ.

Revenue Impact of Proposed Rules

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

a. Employees who would have Remained in Grandfathered Plans and Coverage without the Proposed Rules

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

Under the proposed rules, grandfathered group health plans and grandfathered group health insurance coverage would be allowed to increase

²¹ Kaiser Family Foundation, “2019 Employer Health Benefits Survey,” available at <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/>.

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, 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 effective date of these rules, if finalized, grandfathered group health plans and grandfathered group health insurance coverage could 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 current 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 proposed rules than under the 2015 final rules. However, a plan that increases fixed-amount cost sharing to the maximum amount allowed under the proposed 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 proposed rules for a particular 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 important visits. If individuals generally would forgo relatively unimportant visits, but continue to go to providers when cru-

cial, 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 increases in pre-tax contributions to health FSAs and HSAs would reduce tax revenues. Therefore, the potential increase in tax revenues from premium reductions is affected by whether employees increase their contributions to health FSAs and HSAs. To the extent that employers would have continued to offer a grandfathered plan without changes to the 2015 final rules, under the proposed rules, tax revenues would be expected to increase slightly on net as a result of 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 plan.

b. Employees who would no Longer have been Covered by Grandfathered Plans or Coverage without the Proposed Rules

If the 2015 final rules are not amended, some employers might choose to change their insured grandfathered plans to self-insured, non-grandfathered 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 proposed rules would have little, if any, revenue effect.

Alternatively, assuming the 2015 final rules are not amended, an employer might switch to a fully insured non-grandfathered non-HDHP plan. With respect to small employers, employees who would transfer to the non-grandfathered plan could improve the 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.

Although the type of benefits covered in the 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 are not amended, an employer would not make the switch from a grandfathered plan to a non-grandfathered 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 proposed rules enabled an employer that otherwise might switch to a non-grandfathered plan to retain its grandfathered plan, this revenue gain would not occur, resulting in a revenue loss compared to the status quo under the 2015 final rules. As a further variation, if the employer retained its grandfathered plan under the proposed rules, rather than switching to an HDHP, the revenue loss would be smaller than if the employer had switched to a non-HDHP. Indeed, this could even result in a revenue gain depending on the magnitude of tax-preferred contributions that the employees would have made to HSAs.

Without the change to the 2015 final rules, some employers might replace their grandfathered plan with an individual coverage health reimbursement arrangement (individual coverage HRA). If the employer contributed a similar dollar amount to the individual coverage HRA as it currently does to the grandfathered plan, the employees' tax exclusion would be at least roughly the same as for the grandfathered 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 plan. Thus, under this scenario, there would be very little revenue effect from the proposed rules.

c. Termination of Employer-Sponsored Coverage

If the 2015 final rules are not amended, some employers might drop 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. Those employees with household incomes between 100-400 percent of the federal poverty level may qualify for financial assistance to help pay for their Exchange coverage and related healthcare expenses, which would increase federal outlays, as discussed further below. Others may 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 continued their grandfathered plan under the proposed 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 proposed rules may result in a revenue gain. However, this is likely a small population for an employer that is currently offering a grandfathered 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 plan, which along with an employer shared responsibility payment, if any, may result in an increase in federal revenue. However, if these employees were to remain covered under a grandfathered plan as a result of this proposed rule, there may be a loss in federal revenue for this group.

Overall, there are a number of potential revenue effects of the proposed rules, some of which could offset each other.

Additionally, there is a large degree of uncertainty, including uncertainty with regard to how many plans would continue as grandfathered plans if the 2015 final rules are not amended, what alternatives would be chosen by the employers who do not keep grandfathered plans, and how many plans would make plan design changes as a result of the proposed 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. The Departments seek comments on the impact estimates in this analysis.

Regulatory Review Costs

Affected entities will need to understand the requirements of these proposed rules, if finalized, before they can avail themselves of any of the proposed flexibilities. Sponsors and issuers of grandfathered group health plan coverage would be responsible for ensuring compliance with these proposed rules should they seek to make changes to their plans' cost-sharing requirements. The Departments estimate the burden for the regulatory review to be incurred by the 546,234 grandfathered plan sponsors and issuers of grandfathered group health insurance coverage.

If regulations impose administrative costs on private entities, such as the time needed to read and interpret these proposed rules, if finalized, the Departments should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review and interpret these proposed rules, the Departments assume that the total number of grandfathered group health plan coverage sponsors and issuers that would be able to avail themselves and comply with these proposed rules would be a fair estimate of the number of entities affected.

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

Using the wage information from the Bureau of Labor and Statistics (BLS) for a Compensation and Benefits Manager (Code 11-3141), the Departments estimate that the cost of reviewing this rule is \$127.74 per hour, including overhead and fringe benefits.²² Assuming an average reading speed, the Departments estimate that it would take approximately 0.5 hour for the staff to review and interpret these proposed rules, if finalized; therefore, the Departments estimate that the cost of reviewing and interpreting these proposed rules, if finalized, for each grandfathered group health plan coverage sponsor and issuer is approximately \$63.87. Thus, the Departments estimate that the overall cost for the estimated 546,234 grandfathered group health plan coverage sponsors and issuers would be \$34,887,965.58 ($\$63.87 \times 546,234$ total number of estimated grandfathered plan sponsors and issuers).²³

D. Regulatory Alternatives Considered

In developing the policies contained in these proposed rules, the Departments considered alternatives to the presented proposals. In the following paragraphs,

²² Wage information is available at https://www.bls.gov/oes/current/oes_nat.htm. Hourly wage rate is determined 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 11-3141) is \$63.38, when multiplied by 100 percent results in a total adjusted hourly wage of \$127.74.

²³ 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 (2.4 million \times 0.22 = 527,000), the number of state and local governments multiplied by the percentage of entities offering grandfathered health plans (83,500 \times 0.22 = 18,400), and the 834 issuers offering at least one grandfathered health plan (527,000 + 18,400 + 834 = 546,234).

the Departments discuss the key regulatory alternatives considered.

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 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 proposed policy allows for the desired flexibility, while better reflecting underlying costs for grandfathered group health plans and group health insurance coverage. The Departments acknowledge that the premium adjustment percentage, which the Departments propose to 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 believe 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 health insurance coverage with grandfather status to decrease the contribution rates by more than five percentage points. This 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 proposed 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 need the benefits on which a limit is applied. Therefore, this option was not included in the proposed rules.

The Departments considered options to offset cost-sharing requirement changes by allowing sponsors of group health plans and issuers of 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 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, potentially conflicting with the goal of allowing participants and beneficiaries to retain health plans they like, and still retain grandfather status.²⁴ 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 proposed 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 effective date of the proposed rules, if finalized. 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 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 to encourage cost-effective care was allowing greater cost sharing for brand name drugs if a generic becomes available. However, the Departments decided not to make this change because allowing greater cost-sharing for brand name drugs when a generic becomes available does not result in loss of grandfather status under the 2015 final rules.²⁵ Another 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 plans of such a magnitude that they no longer resemble the plan as it existed as of March 23, 2010. Additionally, the Departments decided that the proposal to change the applicable index for medical inflation provides sufficient flexibility for fixed cost-sharing requirements. This option would give flexibility to grandfathered plans with respect to all fixed-amount cost-sharing requirements, including for out-of-network benefits.

E. Collection of Information Requirements

These proposed rules do not impose new information collection requirements; that is, reporting, recordkeeping,

²⁴ 75 FR 34538, 34547 (June 17, 2010).

²⁵ 80 FR 72192, 72197, 72198 (Nov. 18, 2015).

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 proposed rules do not contain any new information collection requirements, the Departments are continuing 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 provide contact information for participants to direct questions and complaints. Additionally, the Departments are continuing the requirement that a grandfathered group health plan that is changing health insurance issuers is required to provide the succeeding health insurance issuer documentation of plan terms under the prior health insurance coverage sufficient to make a determination 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 exceeded and 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 proposed provisions would 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 proposed 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.

These proposed rules would amend the 2015 final rules to allow greater flexibility for grandfathered group health plans and issuers of grandfathered group health insurance coverage. Specifically, the proposed rules would 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) of the Code. The proposed rules would also include a revised definition of “maximum percentage increase” that would 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 (HMO Medical Centers) and,

if this is the case, the SBA size standard would be \$35 million or less.²⁶ 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 2018 MLR reporting year, approximately 84 out of 498 issuers of health insurance coverage nationwide had total premium revenue of \$41.5 million or less.²⁷ This estimate may overstate the actual number of small health insurance companies that may be affected, since over 72 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 plans. The Departments do not expect any of these 84 potentially small entities to experience a change in revenues of more than three to five percent as a result of these proposed rules. Therefore, the Departments do not expect the provisions of these proposed 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 proposed in these proposed rules, the Departments are not able to accurately ascertain the economic effects on small entities. However, the Departments believe that the flexibilities provided for in these proposed rules would 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 seek comment on ways that the 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.²⁸ The basis of this definition is found in sec-

²⁶ “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.

²⁷ “Medical Loss Ratio Data and System Resources.” CCHIO, available at <https://www.cms.gov/CCHIO/Resources/Data-Resources/mlr.html>.

²⁸ The Department of Labor consulted with the Small Business Administration in making this determination as required by 5 U.S.C. 603(c) and 13 CFR 121.903(c).

tion 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 Department of Labor 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 these proposed 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 Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). Therefore, EBSA requests comments on the appropriateness of the size standard used in evaluating the impact of these proposed rules on small entities.

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

Pursuant to section 7805(f) of the Code, these proposed rules have been submitted to the Chief Counsel for Advocacy of the SBA for comment on their impact on small business.

I. Effects on small rural hospitals

Section 1102(b) of the Social Security Act (SSA) (42 U.S.C. 1302) requires agencies to prepare a regulatory impact analysis 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 of section 603 of the RFA. For purposes of section 1102(b) of the SSA, the HHS

defines a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. These proposed rules would not affect small rural hospitals. Therefore, the Departments have determined that these proposed rules would 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 proposed 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 these proposed rules, if finalized. The Departments estimate that any costs associated with the proposed rules if finalized would not exceed the \$156 million threshold. Thus, the Departments conclude that these proposed rules would 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, these proposed rules do not have any federalism implications. They simply provide

grandfathered 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) 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 proposed rules would 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 these proposed 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 these proposed rules, the Departments certify that the Department of Treasury, Employee Benefits Security Administration, and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached proposed 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." The designation of these proposed rules under Executive Order 13771—as a regulatory action, a deregulatory action, or neither—will be informed by comments received.

V. Statutory Authority

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

The Department of Labor regulations are proposed to be 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 proposed to be 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. 26 CFR Part 602 Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 147

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

Sunita Lough

Deputy Commissioner for Services and Enforcement, Internal Revenue Service

Signed at Washington DC, this 6th day of July, 2020.

Jeanne Klinefelter Wilson
Acting Assistant Secretary

Employee Benefits Security
Administration
U.S. Department of Labor

Dated: July 1, 2020.

Seema Verma,
Administrator,
Centers for Medicare & Medicaid
Services.

Dated: July 6, 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, proposes to amend 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.

* * * * *

Par. 2. Section 54.9815-1251, 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);
- f. In newly redesignated paragraph (g)(5), by revising Examples 3 and 4;
- g. In newly redesignated paragraph (g)(5), by redesignating Examples 5 through 9 as Examples 6 through 10;
- h. In newly redesignated paragraph (g)(5), by adding a new Example 5;

- i. In newly redesignated paragraph (g) (5), by revising newly redesignated Examples 6 through 10;
- j. In newly redesignated paragraph (g) (5), 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 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 this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI-U (unadjusted) published by the Department of Labor for March 2010, using the 1982-1984 base of 100) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

(ii) *Maximum percentage increase defined.* For purposes of this paragraph (g), the term *maximum percentage increase* means:

(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 [the effective

date of final rule], 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 [effective date of final rule], 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 [effective date of final rule]. 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% ($40 - 30 = 10$; $10 \div 30 = 0.3333$; $0.3333 = 33.33\%$). Medical inflation (as defined in paragraph (g)(4)(i) of this section) from March 2010 is 0.2269 ($475 - 387.142 = 87.858$; $87.858 \div 387.142 = 0.2269$). The maximum percentage increase permitted is 37.69% ($0.2269 = 22.69\%$; $22.69\% + 15\% = 37.69\%$). Because 33.33% does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 4. (i) Facts. Same facts as *Example 3*, except the grandfathered group health plan subsequently increases the \$40 copayment requirement to \$45 for a later plan year, effective before [effective date of final rule]. 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% ($45 - 30 = 15$; $15 \div 30 = 0.5$; $0.5 = 50\%$). Medical inflation (as defined in paragraph (g)(4)(i) of this section) from March 2010 is 0.2527 ($485 - 387.142 = 97.858$; $97.858 \div 387.142 = 0.2527$). 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 \times 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*, except the grandfathered group health plan increases the copayment requirement to \$45, effective after [effective date of final rule]. 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*, 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% ($45 - 30 = 15$; $15 \div 30 = 0.5$; $0.5 = 50\%$). 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 [effective date of final rule]. 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% ($15 - 10 = 5$; $5 \div 10 = 0.5$; $0.5 = 50\%$). Medical inflation (as defined in paragraph (g)(4)(i) of this section) from March 2010 is 0.0720 ($415.0 - 387.142 = 27.858$; $27.858 \div 387.142 = 0.0720$). 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 \times 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. The same facts as *Example 6*, 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 [effective date of final rule].

(ii) *Conclusion.* In this *Example 7*, medical inflation (as defined in paragraph (g)(4)(i) of this section) from March 2010 is 0.0720 ($415.0 - 387.142 = 27.858$; $27.858 \div 387.142 = 0.0720$). 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 \times 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 [effective date of final rule] 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).

Definition of Terms

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

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

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

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

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the

new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

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

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

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the

new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

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

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

Abbreviations

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

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.

ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
FR—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.

PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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¹ A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2019–27 through 2019–52 is in Internal Revenue Bulletin 2019–52, dated December 27, 2019.

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