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BENEFITS BRIEF

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Departments Issue Proposed Rule on Expatriate Coverage, Excepted Benefits, Lifetime and Annual Limits, and Short-Term, Limited Duration Insurance

On June 10, 2016, the Departments of Health and Human Services, Treasury, and Labor (collectively, "Departments") published a proposed rule ("Proposed Rule") that primarily provides guidance on the Expatriate Health Coverage Clarification Act ("EHCCA"), which was signed into law on December 16, 2014. In addition, through the Proposed Rule, the Departments provide additional guidance or seek comment on a host of other issues, such as excepted benefits, lifetime and annual limits, and short-term, limited duration insurance.

The Proposed Rule is generally effective for plan or policy years beginning on or after January 1, 2017 and can be relied upon pending the applicability date of the final rule. If the final rule is more restrictive than the Proposed Rule, the final rule will not have retroactive effect.

Below, we highlight the major provisions of the Proposed Rule. For background on the EHCCA, please refer to our prior alert titled "Expatriate Health Coverage Exemption Enacted in Omnibus Spending Bill," dated May 4, 2015.

Prior EHCCA Guidance

Following the enactment of the EHCCA, the Internal Revenue Service ("IRS") issued Notice 2015-43 ("Notice") providing guidance on the provisions of the EHCCA. The Notice provided that, until the issuance of further guidance, taxpayers could use a reasonable good faith interpretation of the EHCCA. The Notice further stated that a plan meeting the requirements outlined in the Departments' prior FAQs on expatriate coverage would be considered a reasonable good faith interpretation of an expatriate health plan under the EHCCA in most instances.

Groom Note: The Proposed Rule does not address whether the reasonable good faith rule will continue to apply. However, in the absence of language to the contrary, it seems that the reasonable good faith rule should continue to apply at least until the final rule is published.

ACA Applicability

The Proposed Rule, consistent with the EHCCA, provides that expatriate health plans are exempt from most of the ACA's market reform requirements. In addition, expatriate health plans are treated as minimum essential coverage ("MEC") for purposes of the individual

mandate, and expatriate health plans covering employees are treated as MEC for purposes of the employer mandate.

Despite the general exemption from ACA market reforms, expatriate health plans remain subject to MEC reporting and employer mandate reporting requirements, subject to a special rule on electronic notices to individuals (discussed below).

The Proposed Rule also contains guidance on the Patient Centered Outcomes Research Institute fee ("PCORI Fee"), health insurer fee ("HIF"), transitional reinsurance program fee ("TRP Fee"), medical loss rebate ("MLR") and 4980I high-cost plan excise tax ("Cadillac Tax"). The Proposed Rule treats each of these requirements as follows:

Fee	Proposed Rule
PCORI Fee	Expatriate health plans are exempt.
HIF	For any fee due after issuance of final rule, a qualified expatriate in an expatriate health plan is not a U.S. health risk.
TRP Fee	Departments' position that, under prior guidance, TRP Fee does not apply to expatriate health plans.
MLR	Expatriate health plans are not subject to the MLR reporting and rebate requirements.
Cadillac Tax	Under EHCCA, Cadillac Tax applies to employer-sponsored coverage for qualified expatriates assigned (not transferred) to work in the United States. Departments to address Cadillac Tax in other guidance.

Expatriate Health Insurance Issuer

The Proposed Rule defines "expatriate health insurance issuer" to be consistent with the EHCCA and clarifies that only issuers licensed to engage in the business of insurance in a State and subject to State insurance laws can be expatriate health insurance issuers. In other words, foreign issuers cannot be expatriate health insurance issuers, and coverage offered by them does not fall within the scope of the EHCCA.

The Proposed Rule also provides that the specific requirements to be satisfied by an expatriate health insurance issuer (pertaining to network adequacy, customer service, claims thresholds, etc.) may be satisfied by two or more entities within the issuer's controlled group or through contracts with third parties. Whether the claims threshold requirement is satisfied is determined using the Department of Treasury's currency exchange rate as of the last day of the preceding calendar year.

Expatriate Health Plan Administrator

The Proposed Rule provides that an expatriate health plan administrator must meet the same set of requirements that apply to expatriate health insurance issuers (pertaining to network adequacy, customer service, claims thresholds, etc.) and that such requirements may be satisfied by two or more entities within the administrator's controlled group or through contracts with third parties.

Groom Note: The Proposed Rule does not state that expatriate health plan administrators are limited to entities within the United States. As such, it seems that self-funded plans administered by foreign entities that satisfy the requirements to be an expatriate health plan administrator could fall within the scope of the EHCCA.

Expatriate Health Plan

The Proposed Rule defines "expatriate health plan" to be consistent with the EHCCA; however, it provides additional detail regarding the specific requirements outlined in the statute. These requirements include (but are not limited to) the following:

- **Substantially All Primary Enrollees Must Be Qualified Expatriates and Substantially All Benefits Must Be Non-Excepted Benefits.** The Proposed Rule defines "substantially all" to mean a 95% threshold, measured on the first day of the plan year. Thus, less than 5% (or less than 5, if greater) of the primary enrollees must not be qualified expatriates and less than 5% (or less than 5, if greater) of the benefits must be excepted benefits.

- **A Plan Sponsor Must Reasonably Believe that Benefits Provide Minimum Value.** A plan sponsor may rely on representations of the issuer or administrator regarding whether the coverage satisfies minimum value requirements unless the plan sponsor knows or has reason to know that the benefits do not satisfy minimum value requirements.

  Groom Note: Generally, minimum value calculations are performed by plan sponsors or plan administrators. In the insured coverage context, the Proposed Rule may have the effect of shifting some of this burden from plan sponsors to issuers.

- **An Expatriate Health Plan Must Allow Opportunity to Demonstrate Creditable Coverage.** Consistent with the EHCCA, the Proposed Rule provides that expatriate health plans must satisfy certain pre-ACA PHSA, Code, and ERISA requirements. The Proposed Rule further provides that such plans are not required to provide certificates of creditable coverage. However, if they impose pre-existing condition exclusions, they must allow individuals an opportunity to demonstrate creditable coverage.

  Groom Note: The Proposed Rule does not provide a format or content for demonstrations of creditable coverage. As such, it seems to provide plans with greater flexibility than the prior requirement that certificates of creditable coverage be provided.

Qualified Expatriates

Consistent with the EHCCA, the Proposed Rule provides that substantially all primary enrollees must be qualified expatriates and outlines three categories of qualified expatriates.

- **Category A (Inpatriates).** The EHCCA and the Proposed Rule define the first category of qualified expatriates to be non-U.S. nationals who are transferred or assigned to the United States for a specific and temporary purpose related to employment, who the plan sponsor reasonably determines require access to health coverage in multiple countries, and who are offered other multinational benefits on a periodic basis. The Proposed Rule elaborates that an individual who is not expected to travel outside the United States at least one time per year during the coverage period would not reasonably require access to health coverage in multiple countries and that a one-time de minimis benefit would not constitute a periodic offer of other multinational benefits.

Groom Note: The Proposed Rule provides that the plan sponsor (*i.e.*, employer) is responsible for determining whether an individual requires access to health coverage in multiple countries. However, it does not specify which entity (the employer or issuer) is to determine how frequently an individual is expected to travel outside the United States or keep track of other multinational benefits.

- **Category B (Expatriates).** The EHCCA and the Proposed Rule define the second category of qualified expatriates to be individuals who work outside the United States for at least 180 days in a consecutive 12-month period. The Proposed Rule clarifies that the 12-month period can be within a single plan year or across two plan years. The Proposed Rule also provides that certain specified services must be provided in the country in which the individual is present in connection with his employment.

- **Category C (Similarly Situated Individuals).** Consistent with the EHCCA, the Proposed Rule defines the third category of qualified expatriates to be individuals expected to travel outside the United States for at least 180 days in a consecutive 12-month period that overlaps with the policy year and whose travel or relocation is not related to employment. For groups expected to travel or be located within the United States, individuals must be expected to reside in the United States for no more than 12 months. These individuals must also meet the PHSA's "associational ties" test. A group of similarly situated individuals that meets all of the criteria in the Proposed Rule will be considered to require access to health coverage and other related services and support in multiple countries.

Groom Note: The Proposed Rule provides that substantially all primary enrollees must be qualified expatriates. However, it does not state whether coverage provided to multiple categories of qualified expatriates would be considered expatriate health coverage. If this is permissible, it is unclear whether a plan that covers Category A or B and Category C individuals would be considered group coverage or individual coverage.

Exclusion From Code Section 162(m)(6) Premiums

Code section 162(m)(6) imposes a cap on the deduction for health insurance executives' pay. The Proposed Rule provides that amounts received in payment for expatriate health plan coverage are excluded from the definition of "premium" under Code section 162(m)(6).

Electronic Delivery of MEC Reporting and Employer Mandate Reporting to Individuals

For purposes of MEC reporting (under Code section 6055) and employer mandate reporting (under Code section 6056), individuals are treated as having consented to electronic delivery unless they explicitly refuse electronic delivery. For this rule to apply, the provider of the statement must notify the individual 30 days prior to the due date for furnishing the first statement that the statement will be provided electronically and must provide an opportunity to opt out.

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Supplemental Health Insurance Coverage

Incorporating guidance from prior FAQs issued by the Departments, the Proposed Rule provides that supplemental health insurance coverage that provides benefits for items and services not covered by the primary coverage will be considered to fill gaps in primary coverage if none of the benefits under the supplemental policy are an essential

health benefit ("EHB"). Supplemental health insurance products that fill in cost sharing and cover additional categories of non-EHBs can be supplemental benefits.

Travel Insurance

The Proposed Rule defines "travel insurance" to mean insurance coverage for personal risk incident to planned travel (*e.g.*, interruption or cancellation of trip, loss of baggage, damages to accommodations or rental vehicles, and sickness, disability, or death during travel) as long as health benefits are not offered on a stand-alone basis and are incidental to other coverage. Major medical plans that provide comprehensive medical protection for travels with trips lasting six months or longer do not constitute travel insurance.

Hospital Indemnity and Fixed Indemnity Insurance

The Proposed Rule provides sample language to meet the new group market requirement (imposed by the Proposed Rule) that hospital indemnity or fixed indemnity insurance applications and enrollment materials provide enrollees or potential enrollees a statement that the coverage is a supplement to (not a substitute for) major medical coverage and that not having MEC could result in additional tax liability.

The Proposed Rule also provides that the amount of benefits under the plan must be determined without regard to the specific type of items or services received, and it includes examples on what would and would not be hospital indemnity or fixed indemnity insurance.

Groom Note: Some hospital indemnity and fixed indemnity products in the current marketplace offer fixed dollar payments for various specified items or services. Under the Proposed Rule, this practice no longer seems to be permissible.

Specified Disease Coverage

In the preamble to the Proposed Rule, the Departments express concern that individuals who purchase a specified disease policy covering multiple diseases or illnesses may incorrectly believe that they have comprehensive medical coverage through such policy. As such, the Departments seek comment on whether protections are needed to ensure that such policies are not mistaken for comprehensive medical coverage and whether to limit the number of diseases or illnesses that may be covered under specified disease policies. Further, the Departments seek comment on whether issuers should be required to disclose that such policies are not MEC.

Short-Term Limited Duration Insurance

The Proposed Rule revises the definition of short-term, limited-duration insurance to be coverage that is less than three months in duration, including any period for which the policy renews or has the option to renew with or without the issuer's consent. The Proposed Rule also provides that a notice must be prominently displayed in the contract and any application materials stating that the coverage is not MEC and a lack of MEC could result in additional tax liability.

EHBs for Lifetime and Annual Limits

For group health plans and health insurance issuers not required to provide EHBs, plans or issuers must define "EHB" to be consistent with one of the benchmark plans applicable in any of the States and including coverage for any additional required benefits considered EHBs, or one of the FEHBP options, supplemented as necessary, to meet the regulatory EHB standards.

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For additional information on the Proposed Rule, please contact the attorneys listed above or your regular Groom Law Group attorney.