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NEW PROPOSED GUIDANCE ON EXPATRIATE HEALTH PLANS, EXCEPTED BENEFITS, ANNUAL AND LIFETIME DOLLAR LIMITS AND SHORT-DURATION MEDICAL INSURANCE

The Departments of Treasury, Labor (DOL) and Health and Human Services (DHHS) recently released proposed guidance on a number of issues that address:

- Expatriate Health Plans
- Excepted Benefits
- Annual and Lifetime Dollar Limits
- Short-Duration Medical Insurance

Some of these issues will affect employers, but others will not. It will depend on the types of benefit plans offered to employees. These proposed regulations request comments from stakeholders. The proposed rules are generally effective for plans or policies beginning on or after January 1, 2017. If final regulations are published that are more restrictive than proposed rules, they will not have a retroactive effective date.

EXPATRIATE HEALTH PLANS

The impact of the Affordable Care Act (ACA) on expatriate health plans was initially unclear. Over the last six years, the Departments have clarified issues through Notices and Frequently Asked Questions (FAQs). In general, the following summarizes how different ACA requirements applied to expatriate health plans until July 2015:

- *Market Reforms.* Expatriate health plans do not have to comply with the ACA's market reforms as long as they continue to comply with the pre-ACA mandates, such as the mental health parity provisions, the HIPAA nondiscrimination requirements, the ERISA claims procedures, and the ERISA reporting and disclosure obligations.
- *Minimum Essential Coverage and Reporting*. Coverage provided under an expatriate health plan is minimum essential coverage. Providers of minimum essential coverage and applicable large employers must comply with the ACA's reporting requirements in Code Sections 6055 and 6056.
- *Taxes and Fees*. PCORI fees and the market share tax do not apply to expatriate plans or to the carrier that insures the expatriate plan.

The Expatriate Health Coverage Clarification Act of 2014 (EHCCA) applies to expatriate health plans issued or renewed on or after July 1, 2015. It modified some of the requirements outlined above, and expanded the definition of expatriate health plans to include self-insured plans. The EHCCA also modified the requirements that a group health plan must meet in order to qualify as an "expatriate health plan" eligible for relief. For example, the EHCCA requires a group health plan to comply with certain ACA requirements, such as the requirements to provide minimum-value coverage and to cover dependents until age 26.

The recently issued proposed regulations integrate the expatriate plan rules into the existing guidance governing various ACA provisions. The following summarizes the provisions that were modified and integrated:

- Generally, the requirements of the ACA do not apply to expatriate health plans, health insurers as related to expatriate health plan coverage or employers as sponsors of expatriate health plans. The only exceptions are:
  - Expatriate health plans are considered minimum essential coverage.
  - The employer shared responsibility provisions ("pay or play") apply to expatriates. This means the expatriate plan must be considered affordable, minimum-value coverage to avoid any potential penalty.
  - The reporting requirements do apply to expatriates, but the new proposed regulations include modifications to electronic delivery requirements. For individuals covered under an expatriate plan, the Form 1095-B or Form 1095-C may be provided to the primary insured electronically, unless he or she has explicitly refused to consent to electronic delivery. This makes sense because insurance carriers generally communicate electronically with expatriates. They only need to revert to paper if the employee requests it.
  - It is not clear how the Cadillac tax will apply to certain qualified expatriates who are assigned (rather than transferred) to work in the United States. The IRS is expected to issue guidance on the specifics related to the Cadillac tax and qualified expatriates.
- The proposed rules reiterate certain aspects of the ACA that do not apply to expatriate coverage:
  - Expatriate health coverage is excluded for reinsurance fee purposes.
  - For the most part, the market share tax will not apply to the expatriate coverage issued by insurers. The tax did apply to specific expatriate health insurance issuers for certain purposes in 2014 and 2015 only.
  - The majority of market reforms do not apply to expatriate coverage, including preventive care coverage, removal of the pre-existing condition limitation, and the prohibition on annual and lifetime limits. The plans need to continue to comply with the pre-ACA mandates, such as the mental health parity provisions, the HIPAA nondiscrimination requirements, the ERISA claims procedures, and the ERISA reporting and disclosure obligations.

These regulations adopt the definition of an expatriate health plan included in the EHCCA. An expatriate health plan means insured or self-funded coverage offered as a group health plan that meets the following requirements:

- Substantially all (95 percent) of the primary enrollees must be *qualified* expatriates.
- Substantially all of the benefits must not be excepted benefits. Plans must provide coverage for inpatient hospital services, outpatient facility services, physician services and emergency services. For most qualified expatriates, these services must be provided in certain countries.
- The plan sponsor has to reasonably believe the benefits offered are of "minimum value" (i.e., the benefits are at a 60 percent or better actuarial value).
- If plan offers coverage to dependent children, it must be offered until the child attains age 26.
- Plan must comply with the pre-ACA mandates, such as the mental health parity provisions, the HIPAA nondiscrimination requirements, the ERISA claims procedures, and the ERISA reporting and disclosure obligations.

For employer-sponsored plan purposes, the rules spell out two types of qualified expatriates:

- ***Category A*** (Inpatriates)– An individual whose skills, qualifications, job duties or expertise has caused the individual's employer to transfer or assign the individual to the United States for a specific and temporary purpose. The employer determines that the individual needs health coverage and support in multiple countries on a periodic basis, recognizing that the expatriate will at times return to his or her home country. This individual is a national from another country.
- ***Category B*** (Expatriates) – A primary insured who works outside the United States for at least 180 days during a consecutive 12-month period that overlaps with the plan year. This individual is a national of the United States.

Ninety-five percent of primary enrollees must be a Category A or Category B qualified expatriate. The majority of expatriate plans offered by employers will be considered qualifying expatriate coverage.

The rules also defined what organizations should be considered expatriate health insurers. The insurer must directly or through a third party:

- Maintain network provider agreements that allow for direct claim payments with health care providers in eight or more countries.
- Maintain call centers in three or more countries and accept calls in eight or more languages.
- Process at least $1 million in claims in foreign currency equivalents each year.
- Make global evacuation/repatriation coverage available.
- Maintain legal and compliance resources in three or more countries
- Have licenses to sell insurance in two or more countries.
- Must offer reimbursement for services in the local currencies in eight or more countries.

Foreign issuers cannot be considered expatriate health insurance issuers and coverage offered by them will not be subject to this rule.

For the most part, formalizing these rules will have little impact on employers offering coverage from an expatriate health insurer.

EXCEPTED BENEFITS

The proposed rules provide important clarifications regarding excepted benefits, which are not subject to many of the ACA's market reforms. The government has defined what is considered "excepted benefits." The Departments are concerned that some employers consider plans to have excepted benefits when they do not actually meet that definition.

The proposed regulations provide the following additional guidance regarding certain excepted benefits:

- If supplemental coverage provides benefits for services not covered by the primary coverage, it can be an excepted benefit if **none** of the benefits are an essential health benefit (EHB) in the state where the policy is issued. If any of the additional benefits are considered EHBs, then the coverage is not a supplemental, excepted benefit.
- If the supplemental health policy fills gaps in cost-sharing (such as deductibles or coinsurance) and covers additional categories of benefits that are not EHBs, it is viewed as a supplemental, excepted benefit (assuming all other requirements are satisfied).
- Travel insurance may fall within the category of "benefits for medical care that are secondary or incidental to other insurance benefits" and may be an excepted benefit. Travel insurance is coverage incident to planned travel of less than six months' duration. To be considered excepted, the travel insurance must provide non-medical benefits, such as coverage for trip interruption and lost baggage. The health benefits cannot be offered as a stand-alone option.
- More details are provided about hospital indemnity and other fixed indemnity coverage. To be considered excepted, these plans must satisfy some new requirements under the proposed rules:
  - The proposed rules have a new notice requirement intended to eliminate confusion about whether the plan provides comprehensive coverage. The plan or issuer must include in any application or enrollment materials provided to participants, **at or before** enrollment, the following notice in **at least a 14-point font:**

    "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES."
  - If participants are required to re-enroll at renewal, this notice must be provided with the re-enrollment materials.
  - To be considered excepted, hospital indemnity or fixed indemnity coverage must pay a fixed amount per day or another time period, such as per week. These plans must pay

the fixed amount without regard to the amount of expenses incurred or the type of services received.

  - The proposed rules include three examples to demonstrate qualifying and non-qualifying hospital or fixed indemnity plans. It is clear that the fixed amount must not be related in any way to the services received. The fixed amount must be based on a fixed period of time and not necessarily on services received. One example had a plan that provide coverage per day, but varied the payment amount based on the type of services received. This plan design is not a hospital indemnity program or a fixed indemnity plan.

- For specified disease coverage, comments are requested on whether the number of diseases covered should be limited, and whether these plans should be required to disclose that they are not considered minimum essential coverage.

More details on excepted health benefits can be found in our *Reform Updates* at http://mcgrawwentworth.com/wp-content/uploads/Reform_Update_100.pdf and http://www.mcgrawwentworth.com/Reform_Update/2014/Reform_Update_79.pdf.

ANNUAL AND LIFETIME DOLLAR LIMITS

These proposed rules made a minor change to previous regulations related to essential health benefits (EHBs). The ACA does not allow annual or lifetime limits on EHBs. The insured plans of large employers (50 or more employees) are not required to cover EHBs. Self-funded plans of any employer size are not required to cover EHBs. However, these employers cannot apply annual or lifetime dollar limits to those benefits. Previous guidance allowed these plans to determine EHBs by using any state's benchmark EHB plan or one of the three largest plans by enrollment as options under the Federal Employee Health Benefit Plan (FEHBP). However, sometimes the benchmark plan does not cover all the services required by the ACA. These plans often have associated supplemental coverage to pay for services that are required but not included in the benchmark plans.

This new guidance simply requires these employers to pick a state EHB benchmark plan or an eligible FEHBP option and include any supplemental coverage that is associated with that plan as part of that EHB plan. Annual or lifetime dollar limits cannot be applied to supplemental benefits associated with the EHB benchmark plan that a plan chooses.

SHORT DURATION MEDICAL INSURANCE

The Departments have heard of insurance carriers offering short-duration medical policies that fail to meet the requirements of the ACA. These plans were initially designed as a short-term limited coverage option when an individual was expecting a gap in coverage. This type of coverage has historically had pre-existing condition limitations and annual and dollar limitations. Many of the provisions would not be permitted under the current ACA rules.

Insurance carriers continue to issue these short-duration plans under the guise that they are "excepted benefits" and not required to comply with the ACA's market reforms. This coverage is not considered minimum essential coverage. These plans will not allow people to avoid the individual mandate penalty.

The proposed regulations set limits on the period of time in which short-duration medical policies can be in effect. Short-term, limited-duration insurance **is** excepted coverage **only if it is in effect for a period of less than three months** (not 12, as is currently the rule). This includes any time period during which the individual can renew the policy. The expiration date has to be specified in the contract. Three months was chosen because it equates to the "short term coverage gap" allowed under the individual mandate. Penalties are not applied if the gap in coverage during the year is less than three months.

These plans must display the following language, in **at least a 14-point font**, in application materials:

> THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Short-duration policies are not typically offered by employers. However, it is important to understand that, going forward, these plans will provide a coverage solution for a maximum of three months only.

CONCLUDING THOUGHTS

These regulations may not affect your plan. However, if you do offer expatriate coverage, hospital indemnity coverage, specified disease coverage or any coverage designed to fill gaps in time, then you should review that coverage to ensure it meets the requirements set forth in these rules.

If your plan does not meet the proposed requirements, you have until the first day of first plan year on or after January 1, 2017 to make any needed modifications.