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Proposed Rules for Expatriate Health Plan and Certain Excepted Benefits under ACA

Newly proposed regulations address the application of the Affordable Care Act to expatriate health plans (whether insured or self-insured), travel insurance and certain other excepted benefits, effective for plan years beginning on and after January 1, 2017. These regulations include proposed conforming amendments relating to the Expatriate Health Coverage Clarification Act of 2014 (EHCCA) which generally exempts expatriate health plans from many of the ACA requirements. The proposed rules mainly reflect prior guidance as well as the requirements of EHCCA.

It is important to remember that expatriates may still be subject to the individual mandate (but these plans may qualify as minimum essential coverage), employers still need to comply with the employer penalty rules, and the health plan reporting obligations through Forms 1094/1095 continue to apply to those covered by these plans.

Expatriate Health Plans

- Expatriate Health Plan (EHP), consistent with EHCCA, is a plan offered to qualified expatriates that satisfies certain requirements; substantially all primary enrollees must be qualified expatriates.
  - An EHP either must be issued by an expatriate health insurance issuer (insurer) or be administered by an expatriate health insurance administrator (as defined in the regulations), if the plan is self-insured.
  - If the individual is not a US national and resides in his country of citizenship, that person is not a primary enrollee.
  - "Substantially all" means 95%, determined on the first day of the plan year.
  - There are three types of qualified expatriates, two of which are employment related:
    - Category A, those assigned in the US: an individual (who is not a US national) transferred or assigned by the employer to the US for a specific and temporary purpose due to his skills or job duties and who needs access to health coverage in multiple countries (that is, he must be expected to travel outside the US during the temporary assignment), and is offered other multinational benefits on a periodic basis, such as tax equalization, compensation for cross-border moving expenses, or compensation to return to the individual's home country (this cannot be a one-time de minimis benefit).
    - Category B, those assigned outside the US: an individual who works outside the US for at least 180 days in a consecutive 12-month period that overlaps with a single plan year or across two consecutive plan years.

- Highlights regarding plan requirements:
  - It must cover certain types of services, including inpatient hospital, outpatient facility services, physician services and emergency services in certain identified countries;
  - The plan sponsor must reasonably believe it satisfies the minimum value requirements;
  - If dependents are coverage, coverage must continue until the child is age 26;
  - It must reimburse services in the local currency in 8 or more countries;
  - It must comply with the pre-ACA requirements, such as reducing pre-existing condition exclusions by creditable coverage

- Consistent with EHCCA, the market reform provisions of ACA do not apply to EHPs (these include the 90 day waiting period requirement, no cost-sharing for preventive care, the patient protections relating to emergency care, coverage for clinical trials, etc.).

- The PCORI fees do not apply to EHPs.

Supplemental Benefits, Travel Insurance, Hospital Indemnity

The rules regarding excepted benefits are critical for employers providing coverage that provides some medical care but that cannot comply with certain provisions of ACA, such as the prohibition of annual or lifetime dollar limits. The following proposed regulations provide additional guidance with respect to certain excepted benefits:

- As provided in FAQs XXIII, 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 in which the policy is issued. If any of the additional benefits are an EHB, then the coverage is not a supplemental, excepted benefit.
  - If the supplemental health policy fills in cost sharing (such as deductibles) and covers additional categories of benefits that are not EHB, it would also be 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 6 months that also provides benefits such as for interruption, cancellation, lost baggage, etc. and provided the health benefits are not offered as a stand-alone option.

- Hospital indemnity and other fixed indemnity insurance may be non-coordinated excepted benefits under revised rules intended to avoid confusion by participants who may otherwise think they provide comprehensive coverage.
  - Enrollment material must include a statement that the coverage is a supplement to, not a

substitute for, major medical coverage and that a lack of MEC may result in an additional tax (specific language is provided).
    - The amount of benefit provided must be determined without regard to the type of item or service provided (it cannot vary by whether it is a doctor's visit, prescription or otherwise).

- Short-term, limited duration insurance is excepted coverage only if it is for a period of less than three months (not 12 as is currently the rule), including the period during which the individual can renew the policy.