Proposed Rule on Expatriate Health Plans, Excepted Benefits, Essential Health Benefits, and Short-Term, Limited-Duration Insurance

In a tri-agency proposed rule, the Department of Labor (DOL), Department of Health and Human Services (HHS), and Department of Treasury (Treasury) (collectively, Departments) have published guidance discussing expatriate health plans (expat plans), excepted benefits, essential health benefits (EHBs), and short-term, limited-duration insurance.

Expatriate Health Plans

The proposed rule would allow expatriate health plans, employers as sponsors of expatriate health plans, and expatriate health plan insurers to be exempt from certain Patient Protection and Affordable Care Act (ACA) requirements such as medical loss ratio, and the PCORI fee.

Expatriate plans are group health plans or individual coverage for which substantially all primary enrollees (95 percent) are qualified expatriates. Primary enrollees are all individuals other than a dependent, spouse, or beneficiary. Qualified expatriates must meet one of the following three definitions:

- Individuals who, because of their skills, qualifications, job duties, or experience are transferred or assigned to the United States for a specific and temporary employment purpose and who are reasonably determined to require health insurance and other related services in multiple countries (that is, are expected to travel out of the United States at least once per year) and who are offered multinational benefits beyond one-time*, de minimis* benefits;
- Individuals who work outside the United States for at least 180 days in a consecutive 12-month period that overlaps with a plan year; or,
- Individuals who are members of a group:
    1) formed for traveling or relocating outside the United States for an educational or service purpose (such as students or missionaries), and
    2) not formed primarily for the sale of health insurance, and who are determined by the departments to require access to health insurance in multiple countries.

An individual must travel or reside outside the United States for at least 180 days during a 12-month period (or, if the coverage is for less than a year, for at least half the period), but may not be expected to travel or reside outside the United States for more than 12 months, and may not be traveling or residing outside the United States for employment purposes.

Expatriate plans have a multitude of items they must cover. They must:

- not consist substantially of all excepted benefits;
- cover inpatient hospital services, outpatient facility services, physician services, and emergency services in the United States and in the country from which the qualified expatriate was assigned or in which he or she is employed, and in countries designated by the departments;
- provide at least minimum (60 percent actuarial) value;
- if the plan provides dependent coverage, cover adult children up to age 26;
- be issued by an insurer or administered by a plan administrator that is licensed to operate in more than two countries, has provider networks in eight or more countries, maintains call centers in three or more countries and in eight or more languages, processes at least $1 million in claims a year, makes available global evacuation/repatriation agreements, maintains legal and compliance resources in three or more countries, and offers reimbursement for items and services in the local currency of eight or more countries;
- satisfy health reform requirements of federal law that applied before the ACA, including the pre-existing condition exclusion limitations imposed by HIPAA;
- if an insured plan, be offered by a U.S.-licensed health insurer. United States, in this instance, includes all 50 states, the District of Columbia, and Puerto Rico. It does not include other territories.

Excepted Benefits

The proposed rule also discussed excepted benefits, which are generally exempt from HIPAA and ACA requirements. Excepted benefits are not minimum essential coverage (MEC) and can cover things such as limited scope dental and vision care, workers' compensation, and accidental death and dismemberment coverage. Individuals with an excepted benefit can still qualify for an advance premium tax credit (subsidy) to purchase coverage in the Marketplace.

The proposed rule provides further requirements of group policies that cover fixed-dollar indemnity coverage, in order to remain an excepted benefit. The coverage must pay a fixed amount per day or over another time period without regard to the cost of service or item provided to the beneficiary. Therefore, a fixed dollar indemnity policy could not pay a fixed percentage of the cost of hospitalization, or pay a different amount for hospitalization versus a physician's services. The policy must also include warnings that it is not major medical coverage and does not qualify as MEC in the application, enrollment, and re-enrollment materials.

Supplemental coverage generally for group excepted benefits must be designed to fill in gaps in cost sharing or primary coverage, or to provide non-essential health benefits in the state in which the coverage is offered. Supplemental coverage will not become supplemental with just coordination of benefit requirements.

Travel Insurance

The proposed rule defines travel insurance to mean coverage for personal risks incurred during planned travel including:

- Trip interruption or cancellation
- Loss or damage to luggage
- Damage to accommodations or rental vehicles
- Sickness, accident, disability or death coverage during travel, but only if the health benefits are not offered on a comprehensive, standalone basis and are incidental to other coverage

Furthermore, a travel insurance policy cannot cover trips longer than six months and should not be intended to cover people employed overseas.

Essential Health Benefits

The proposed rule also suggests amending regulations that define an EHB-benchmark plan to reflect the possibility that the base-benchmark plan could require supplementation.

Short-Term, Limited-Duration Insurance Final Rule

After the Departments published its proposed rule, the Departments published a final rule to address the definition of short-term, limited-duration insurance. The final rule applied to short-term, limited-duration insurance policies starting on October 2, 2018.

The final rule redefines short-term, limited-duration insurance as health coverage with an initial contract term of less than 12 months and a total duration of up to 36 months, including renewals or extensions under the same insurance contract.

An insurer must prominently display the following consumer notice in at least 14-point type in the contract, application, and coverage enrollment materials:

> This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not “minimum essential coverage.” If you don’t have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

The notice’s last two sentences must appear only on policies sold on or after October 2, 2018, that have a coverage start date before January 1, 2019.

States can continue to apply state law requirements to short-term, limited-duration insurance. For example, states can require short-term, limited-duration insurance to have a shorter maximum initial

contract term or shorter maximum duration (including renewals and extensions), or both. States can also require insurers to provide additional consumer disclosures. Further, states can prohibit the sale of short-term, limited-duration insurance.

In the final rule, the Departments indicate that a person's loss of eligibility for short-term, limited-duration insurance creates a HIPAA special enrollment opportunity to enroll in a group health plan.

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