



AMERICAN BENEFITS COUNCIL

August 9, 2016

Submitted electronically via <http://www.regulations.gov>

Secretary Sylvia M. Burwell
U.S. Department of Health and Human
Services

Acting Administrator Andrew M. Slavitt
Centers for Medicare & Medicaid
Services
U.S. Department of Health and Human
Services

Assistant Secretary Phyllis C. Borzi
Employee Benefits Security
Administration
U.S. Department of Labor

Mr. John Dalrymple
Deputy Commissioner for Services and
Enforcement
Internal Revenue Service
U.S. Department of the Treasury

CC:PA:LPD:PR (REG-135702-15),
Internal Revenue Service,
P.O. Box 7604,
Ben Franklin Station
Washington, DC 20044

Re: Proposed Rule - Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance

Dear Secretary Burwell, Acting Administrator Slavitt, Assistant Secretary Borzi, and Deputy Commissioner Dalrymple:

We write on behalf of the American Benefits Council ("Council") to provide comment in connection with the proposed rule ("Proposed Rule") published in the Federal Register on June 10, 2016 by the Internal Revenue Service ("IRS"), the Department of Labor ("DOL"), and the Department of Health and Human Services ("HHS") (collectively, the "Agencies"). The Proposed Rule would implement the

Expatriate Health Coverage Clarification Act (“EHCCA”) and provide additional guidance regarding excepted benefits, lifetime and annual limits, and short-term, limited-duration insurance.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council’s members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

We appreciate the opportunity to provide comments to the Agencies with regard to the implementation of the EHCCA and contemplated changes pertaining to excepted benefits.

GOOD FAITH INTERPRETATION OF REQUIREMENTS

In IRS Notice 2015-43, the IRS announced that taxpayers are allowed to use a reasonable good faith interpretation in applying the requirements of the EHCCA. In the preamble to the Proposed Rule, the Agencies state that relevant portions of IRS Notice 2015-43 are discussed therein. However, neither the preamble nor the Proposed Rule itself discusses the ability of plan sponsors and health insurance issuers to apply the requirements of the EHCCA and the Proposed Rule using a reasonable good faith interpretation.

We appreciate the additional guidance provided in the Proposed Rule regarding the provisions of the EHCCA. We note, however, that expatriate health plans face unique administrative challenges related to the provision of expatriate coverage, including regarding the tracking of covered individuals, the provision of disclosures to such covered individuals (given that they may be globally mobile at any point in time), an asymmetry of knowledge regarding what, if any, other benefits may be offered to such covered individuals, and the coordination of such expatriate coverage with applicable foreign laws. Due to these unique challenges, we urge the Agencies to adopt a rule allowing plan sponsors and health insurance issuers to apply the requirements of the EHCCA and the Proposed Rule using a reasonable good faith interpretation. Inclusion of a good faith safe harbor would reduce the administrative burdens that expatriate health plans face and ensure greater compliance with the EHCCA.

INTERPRETATION OF “SUBSTANTIALLY ALL” PRIMARY ENROLLEES AND “SUBSTANTIALLY ALL” BENEFITS

The EHCCA requires that “substantially all” primary enrollees in an expatriate health plan must be qualified expatriates and substantially all of the benefits provided

under the plan or coverage must be benefits that are not excepted benefits. The Proposed Rule restates these requirements and defines “substantially all” to mean that at least 95% of the primary enrollees must be qualified expatriates and at least 95% of the benefits under the expatriate health plan are not excepted benefits. Compliance with these thresholds is to be measured as of the first day of the plan year.

We appreciate the clarity provided by the definition proposed by the Agencies. We are concerned, however, that the rule may be very difficult to apply since it is possible that expected plan enrollment may vary from actual enrollment as of the first day of the plan year. The use of a 5% threshold for coverage of individuals who are not qualified expatriates increases the likelihood that certain plans that expected to meet the threshold based on estimates during annual enrollment could find themselves outside the definition of “expatriate health plan” solely as a result of an asymmetry in expected enrollment and actual enrollment. Additionally, we are concerned that the use of such a 5% threshold could result in the exclusion from the EHCCA of many expatriate health plans that are currently offered by plan sponsors and health insurance issuers.

To continue to provide expatriate health plans with flexibility in complying with the “substantially all” requirement, we request that final regulations provide a definition of “substantially all” that uses a facts and circumstances evaluation rather than a strict numerical threshold. Alternatively, we request that the final regulations provide a safe harbor definition of “substantially all” that uses an 85% threshold (providing that the number of individuals who are not qualified expatriates cannot exceed the greater of 15% of or 15 primary enrollees), and which would continue to allow plans to qualify as expatriate health plans even if the 85% threshold is not satisfied, if the facts and circumstances otherwise demonstrate that policy goals would be well-served by treating the plan(s) as expatriate health plans for purposes of the EHCCA and implementing regulations.

CATEGORY A QUALIFIED EXPATRIATES

The EHCCA and the Proposed Rule contain three categories of qualified expatriates (referred to in the Proposed Rule as Category A, Category B, and Category C). The EHCCA provides that a Category A expatriate is an individual who is transferred or assigned to the United States for a specific or temporary purpose tied to his or her employment. In connection with such transfer or assignment, the plan sponsor must reasonably determine that the individual requires access to health insurance or other related services and support in multiple countries. Further, such an individual must be offered other multi-national benefits on a periodic basis.

The Proposed Rule reiterates the requirements above and imposes additional non-statutory requirements. In relevant part, the Proposed Rule states that individuals who are 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 and other related services and support in multiple countries.

We appreciate the Agencies’ attempt to clarify the statutorily-imposed plan sponsor obligation to determine whether an individual reasonably requires access to health coverage and other related services or support in multiple countries. However, the clarification places undue burden on plan sponsors to track whether individuals may travel outside the United States during the coverage period. Further, to the extent an individual is in the United States for a period of time less than a calendar year and is covered under the expatriate plan only during such period (*e.g.*, an individual who is sent to work in the United States for only part of a calendar year), it appears that, under the Proposed Rule, the individual would no longer qualify as a qualified expatriate. If a plan covers many such individuals, which is common practice, such coverage would no longer qualify as expatriate coverage. To avoid this adverse consequence with significant market impact, we encourage the Agencies to remove this limitation.

CATEGORY B QUALIFIED EXPATRIATES

The Proposed Rule provides that an individual can be categorized as a Category B qualified expatriate only if the individual is a national of the United States who is working outside the United States for at least 180 days in a consecutive 12-month period that overlaps with a single plan year, or across two consecutive plan years.

We appreciate that the Proposed Rule largely tracks the description of Category B expatriates contained in the EHCCA. However, we note that the requirement that an individual be a national of the United States is not present in the EHCCA and has been added by the Agencies in the Proposed Rule. We believe that the addition of this language has far-reaching, unintended consequences, and as such, should be deleted.

By limiting Category B expatriates to nationals of the United States who are working outside the United States for a period of time, the Proposed Rule excludes third-country nationals working outside their home country (*e.g.*, a German national working in France) from the definition of “qualified expatriate.” In addition, these individuals are not excluded from the definition of “primary enrollee” contained in the Proposed Rule. As such, the Proposed Rule would threaten the existing expatriate status of many plans currently offered in the market, which cover both U.S. and non-U.S. nationals working outside the United States (and not in the country of their citizenship). This exclusion, combined with the high “substantially all” threshold addressed above, increases the likelihood that existing expatriate health plans could lose their expatriate health plan status.

To limit the adverse impact to existing expatriate health plans, we urge the Agencies to remove the limitation requiring that Category B expatriates be nationals of the United

States. Alternatively, we ask that the Agencies exclude these third-country nationals from the definition of “primary enrollee.”

CATEGORY C QUALIFIED EXPATRIATES

The Proposed Rule describes the third category of qualified expatriates (Category C expatriates) as those individuals who are members of a group of similarly situated individuals that is formed for the purpose of traveling or relocating internationally in service of one or more purposes listed in Internal Revenue Code section 501(c)(3) or (4), or similarly situated organizations or groups, and meet certain other conditions.

In relevant part, the Proposed Rule provides that, in the case of a group organized to travel or relocate outside the United States, the individual must be expected to travel or reside outside the United States for at least 180 days in a consecutive 12-month period that overlaps with the policy year. In the case of a group organized to travel or relocate within the United States, the individual must be expected to travel or reside in the United States for not more than 12 months.

The Proposed Rule’s inclusion of the requirement that Category C expatriates travel or reside within or outside the United States for a specified period of time is not statutorily supported. The EHCCA defines Category C expatriates solely by reference to the purpose for which the group of similarly situated individuals is formed. There is no statutory requirement that this category of expatriates meet certain time thresholds. In this regard, the statutory language describing Category C expatriates differs from the language describing Category B expatriates, which specifically references a time period during which an individual must work outside the United States. Thus, Congress specifically chose to define Category B expatriates by reference to the time period during which they work outside the United States and to not impose a similar time restriction to Category C expatriates. As such, the Agencies’ inclusion of a timing restriction is contrary to the statutory language and congressional intent.

To more closely align the EHCCA and implementing regulations, we urge the Agencies to eliminate the requirement that Category C expatriates travel or reside within or outside the United States for a specific period of time. Instead, we recommend a requirement that Category C expatriates be expected to travel or reside within or outside the United States for a specific or temporary purpose. We believe that this approach is consistent with the language used in the Proposed Rule to describe Category A expatriates and will reduce burdens related to the administration of expatriate health plans covering Category C expatriates.

ELECTRONIC DISCLOSURE OPT-OUT NOTICES

The Proposed Rule allows expatriate health plans to treat individuals as having consented to electronic disclosure of individual statements required to be provided under Internal Revenue Code sections 6055 and 6056 if individuals are provided with a notice that the statements will be furnished electronically. The presumption of consent does not apply if the recipient explicitly refuses electronic disclosure. The Proposed Rule requires that the advance notice of electronic disclosure be provided at least 30 days prior to the due date for furnishing the first statement that the plan or issuer intends to furnish electronically to the individual.

We appreciate the flexibility offered to expatriate health plans with respect to the disclosure requirements – specifically regarding the use of electronic disclosure. We believe additional clarity regarding the requirement to provide advance notice of the use of electronic disclosure would be helpful to plan sponsors and health insurance issuers.

As the Agencies are aware, expatriate health plans cover globally mobile individuals, many of whom may travel around the world and be in multiple locations and/or have multiple addresses during the period of coverage. To ensure that these individuals receive the advance notice of electronic disclosure and reduce administrative burdens associated with identifying a covered individual's current address and mailing the disclosure to multiple addresses around the world, we urge the Agencies to clarify that the advance notice of electronic disclosure may be provided as part of the enrollment materials for expatriate health plan coverage. This clarification would be consistent with the existing language in the Proposed Rule, not limit individuals' opt-out rights, and minimize administrative burden.

HOSPITAL INDEMNITY AND OTHER FIXED INDEMNITY INSURANCE

In addition to implementation of the EHCCA, the Proposed Rule addresses hospital indemnity and other fixed indemnity insurance offered in the group insurance markets. The Proposed Rule imposes two requirements on such coverage. First, the Proposed Rule requires that group hospital indemnity and other fixed indemnity insurance include a statement that the coverage provided under the policy is a supplement to major medical coverage and a lack of minimum essential coverage could result in additional tax liability for an individual. The Proposed Rule states that this statement must be included in applications and enrollment materials. Second, the Proposed Rule requires that hospital indemnity and other fixed indemnity insurance policies provide coverage without regard to the type of items or services received.

Group hospital indemnity and other fixed indemnity insurance is generally sponsored by employers to provide employees with a fixed dollar benefit per period,

day, or service that can be used by the employee for any purpose he or she chooses. An employee might choose to use the cash benefit to pay any out-of-pocket costs related to the medical event triggering the payment (*e.g.*, hospitalization) or use the cash payment to pay for travel expenses, child care costs or other financial needs. Coverage under hospital indemnity and other fixed indemnity insurance policies is not intended to be health insurance.

The coverage is typically based on the type of service at issue in order to reflect the financial exposure that individuals may face due to various medical events. For example, a Statistical Brief published by the Agency for Healthcare Research and Quality explains, “In 2012, mean hospital costs per stay for surgical stays (\$21,000) were 2.5 times the mean costs for medical stays (\$8,500) and approximately five times the mean costs for maternal and neonatal stays (\$4,300).”¹ These differing medical expenses also present differing potential exposure for unmet non-medical costs due to the severity of the underlying health issue – costs that may involve travel to receive treatment, or simply additional funds to meet living expenses when a family member is in the hospital or experiencing other types of medical issues. Thus, by varying benefits based on the type of service or hospital stay, health insurance issuers are able to provide valued coverage to employers and employees through hospital indemnity and other fixed indemnity policies. The cash payment provides needed financial security and the need will vary based on the medical service, even in situations where the individuals’ major medical coverage covers most, or even all, of the medical expenses.

These policies do not, and are not intended to, serve as alternatives to major medical coverage. In fact, virtually all of the Council’s employer plan sponsors offer group health benefits to their employees and dependents. To the extent they offer group hospital indemnity or other fixed indemnity coverage, such plans are in addition, not an alternate, to major medical coverage.

We also note that medical costs have increased since these policies were first introduced.² In addition, a growing number of employees and consumers are enrolled in high deductible health plans either through their employer-sponsored plans or via the individual insurance market. This means that employees and consumers are facing greater out-of-pocket costs. That trend is likely to continue, particularly for employers who are turning to higher deductible and other cost-share plans in order to avoid the “Cadillac tax” on high cost health plans.³

Given the increasing out-of-pocket medical expenses being incurred by consumers, as well as non-medical expenses consumers experience in the event of illness, hospital

¹ Brian Moore et al., *Costs for Hospital Stays in the United States, 2012*, Agency for Healthcare Research and Quality Statistical Brief #181 (October 2014).

² *Id.*

³ See Internal Revenue Code § 4980I.

indemnity and other fixed indemnity insurance policies are an important option to help employees and other consumers with expenses. This is especially so for lower-income individuals, who may otherwise lack sufficient personal assets to meet their out-of-pocket costs, and household or other expenses that arise during a hospitalization or illness.

In addition to the cost considerations highlighted above, we note that the examples provided in the Proposed Rule do not align with applicable statutory language. In relevant part, the statute provides that independent, noncoordinated hospital indemnity or other fixed indemnity insurance constitutes an excepted benefit if, *inter alia*, “benefits are paid with respect to an event. . . .”⁴ The statute does not provide that benefits paid with respect to an event must be restricted based on the type of event at issue. The addition of the requirement that benefits must be determined without regard to the type of items or services received, which is described in the preamble and illustrated in the examples added by the Proposed Rule, is not supported by the statutory language and would add restrictions to coverage that Congress did not intend.

In addition to not being supported by statutory language, the addition of restrictions described above is an overreach of the Agencies’ authority. The Circuit Court for the D.C. Circuit recently addressed a similar attempt by the Agencies to add additional requirements to certain excepted benefits. Specifically, in the context of an additional requirement for minimum essential coverage as a criterion for individual fixed indemnity policies, the Court stated, “Thus, where Congress exempted all such conforming plans from the PHSA’s coverage requirements, HHS, with its additional criterion, exempts less than all. Disagreeing with Congress’s expressly codified policy choices isn’t a luxury administrative agencies enjoy.”⁵

In order for plan sponsors and health insurance issuers to continue to provide the greatest value to employees and other consumers through hospital indemnity and other fixed indemnity insurance policies, we strongly urge the Agencies to modify the Proposed Rule to allow such policies to provide benefits as a fixed amount per event (or in the alternate, per period of time), permitting variances based on the type of event at issue.

According to the preamble to the Proposed Rule, the Agencies are concerned that some individuals may incorrectly understand hospital indemnity and other fixed indemnity policies to be comprehensive major medical coverage that would constitute minimum essential coverage.

We agree that it is important that employees and consumers be well-informed as to

⁴ Internal Revenue Code §§ 9831(c)(2)(C) and 9832(c)(3).

⁵ *Cent. United Life Ins. Co. v. Burwell*, No. 15-5310, 2016 WL 3568084, at *2 (D.C. Cir. July 1, 2016)

their benefits and insurance coverage. We believe that concerns regarding any potential consumer confusion regarding the nature of such policies are best addressed with disclosure requirements. We support the disclosure requirements proposed by the Agencies in the Proposed Rule.

Regarding the Agencies' concern about potential consumer confusion, we note that the Public Health Service Act recognizes states as the primary regulators of health insurance.⁶ Existing state laws provide substantial protections for consumers, including disclosure requirements to avoid consumer confusion. For example, state regulators review and approve insurance policies, specify content requirements for policy documents, and impose comprehensive restrictions on marketing. States also ensure consumer protection by investigating consumer complaints on an ongoing basis. Given the robust consumer protections already in place, we encourage the Agencies to continue to recognize states as the primary regulators of hospital indemnity and other fixed indemnity products and not impose an overlay of additional or conflicting requirements over the several state requirements that carriers must satisfy. Alternatively, we encourage the Agencies to make any such requirements, including disclosure language, consistent with the requirements and language applicable to such policies in the individual market.⁷

Finally, there are a host of transition issues that should be considered as part of final rulemaking. For example, many hospital indemnity and other fixed indemnity policies are sold with multi-year guarantees, allowing consumers to purchase such policies for more than one policy year at a guaranteed rate and with guaranteed coverage offerings.

To the extent the requirements of the Proposed Rule are adopted, we urge the Agencies to provide for a delayed effective to ensure that issuers and employers have sufficient time to implement any required changes to the coverage. Accordingly, we request that the final rule become effective no sooner than policy years beginning on or after the one-year anniversary of the publication of the final rule in the Federal Register. Additionally, we request that the final rule allow current coverage to be provided for the duration of any current contract, including any extensions and renewals. Alternatively, we request the Agencies allow existing policies that have been sold with multi-year guarantees to be grandfathered for the duration of a defined transition period.

SPECIFIED DISEASE COVERAGE

In the preamble to the Proposed Rule, the Agencies state their concern that specified disease and illness policies that provide coverage for multiple diseases or illnesses may

⁶ 42 U.S.C. § 300GG-61(A); 65 Fed. Reg. 45786, 45787 (1999).

⁷ See 45 CFR § 148.220(b)(4)(iv).

cause consumer confusion regarding whether such coverage constitutes comprehensive medical coverage. The Agencies request comments on whether to limit the number of diseases or illnesses covered under such policies and whether health insurance issuers should disclose that such policies are not minimum essential coverage.

As we note above, medical costs have steadily increased over the years, and the increase in costs has varied for different types of services. Often, the services being received are directly related to, and may vary based on, the disease or illness at issue. In many instances, individuals who have one disease may also suffer from other related or unrelated diseases. Additionally, for certain diseases or illnesses, it may not be actuarially sound to offer a stand-alone policy for that one disease or illness.

By offering coverage for more than one disease or illness, issuers of specified disease policies are able to provide coverage that best aligns with the needs of employers, employees and other consumers. Further, as we note above for hospital indemnity and other fixed indemnity coverage, these policies provide cash payments that may be used by the insured for any purpose. Such coverage provides financial security and does not, and is not intended to, serve as an alternative to major medical coverage.

In addition, we note that limiting the number of diseases or illnesses that may be covered in a specified disease policy is also not supported by statutory language. In relevant part, the statute provides, “‘excepted benefits’ means benefits under one or more (or any combination thereof)” of a number of different types of benefits, including, “coverage only for a specified disease or illness.”⁸ This language can reasonably, and perhaps must, be read to allow the combining of multiple excepted benefits. Accordingly, the addition of a numerical limitation would be contrary to the express statutory language, as well as congressional intent.

To allow issuers to offer coverage for diseases and illnesses based on consumer need and to ensure coverage for diseases that may not otherwise be covered if a numerical limitation on the number of diseases or illnesses that can be covered is imposed, we urge the Agencies to continue to permit flexibility in structuring specified disease or illness policies. To the extent that the Agencies are considering changes to existing regulations and guidance for specified disease or illness policies, we strongly urge that such changes be proposed subject to public notice and comment rulemaking.

We believe that any concerns related to potential consumer confusion regarding these types of policies are adequately addressed under existing state regulation, as noted above in the context of hospital indemnity and other fixed indemnity insurance. To the extent that the Agencies find that federal regulation is desirable, we think potential consumer confusion can be appropriately addressed through enhanced disclosure requirements rather than imposing structural changes to policies that could

⁸ Internal Revenue Code § 9832(c).

result in Americans losing access to important coverage options. We also recommend that any changes to disclosure requirements be consistent with the requirements and language applicable for hospital indemnity and other fixed indemnity insurance.

TRAVEL INSURANCE

The Proposed Rule also provides guidance on travel insurance. Specifically, the Proposed Rule defines travel insurance as insurance coverage for personal risks incident to planned travel, including sickness, accident, disability, or death occurring during travel, provided that health benefits are not offered on a stand-alone basis and are incidental to other coverage.

We note that insurance issuers offering such coverage may not know whether an individual purchasing travel insurance coverage also has major medical coverage. Often, individuals are enrolled in major medical coverage provided by their employers, spouse's employers, or other health insurance issuers, and an insurer offering travel insurance may not have sufficient information to determine whether the travel insurance coverage is incidental to other independent coverage. As such, we request the Agencies to clarify the Proposed Rule to state that health benefits under a travel insurance policy must be incidental *to other benefits offered under that policy*, and not other coverage more generally.

REGULATORY FLEXIBILITY ACT

The Agencies have certified that the proposed rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act, 5 U.S.C. §§ 601-612. The Agencies determined that because "the majority of small issuers belong to larger holding groups, many if not all are likely to have non-health lines of business that would result in their revenues exceeding \$38.5 million [the threshold for being considered a small entity]."⁹ This conclusion does not account for the direct and significant impact that the proposed regulations would have on small businesses, small organizations and small governmental jurisdictions that sponsor group benefits. As detailed above, under the proposed regulations, these entities would not be able to offer, or continue to offer, their employees the valuable hospital indemnity, other fixed indemnity, and specified disease insurance policies that are currently available in the marketplace. This would result in additional administrative costs for small employers who would be forced to eliminate an existing benefit and change their plan offerings, likely at a higher cost. The proposed rule would also result in significant out-of-pocket costs for employees who would lose the cash benefits that these plans provide.

⁹ 81 Fed. Reg. 38020, 38036 (June 10, 2016).

* * *

Thank you for considering these comments submitted in response to the Proposed Rule. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

A handwritten signature in black ink that reads "Kathryn Wilber". The signature is written in a cursive, flowing style.

Kathryn Wilber
Senior Counsel
Health Policy