DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1, 46, 54, 57, and 301

[REG–135702–15]

RIN 1545–BN44

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AB75

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, 147, 148, and 158

[CMS–9932–P]

RIN 0938–AS93

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

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This document contains proposed regulations on the rules for expatriate health plans, expatriate health plan issuers, and qualified expatriates under the Expatriate Health Coverage Clarification Act of 2014 (EHCCA). This document also includes proposed conforming amendments to certain regulations to implement the provisions of the EHCCA. Further, this document proposes standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits and revisions to the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage. These proposed regulations affect expatriates with health coverage under expatriate health plans and sponsors, issuers and administrators of expatriate health plans, individuals with and plan sponsors of travel insurance and supplemental health insurance coverage, and individuals with short-term, limited-duration insurance. In addition, this document proposes to amend a reference in the final regulations relating to prohibitions on lifetime and annual dollar limits and proposes to require that a notice be provided in connection with hospital indemnity and other fixed indemnity insurance in the group health insurance market for it to be considered excepted benefits.

DATES: Comments are due on or before August 9, 2016.

ADDRESSES: Comments, identified by ''Expatriate Health Plans and other issues,'' may be submitted by one of the following methods:

Hand delivery or mail: Written comment submissions may be submitted to CC:PA:LPD:PR (REG–135702–15), Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Comment submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–135702–15).

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

Comments received will be posted without change to *www.regulations.gov* and available for public inspection. Any comment that is submitted will be shared with the Department of Labor (DOL) and Department of Health and Human Services (HHS). Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments may be posted on the Internet and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records.

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, with respect to the treatment of expatriate health plan coverage as minimum essential coverage under section 5000A of the Internal Revenue Code, John Lovelace, at 202–317–7006; with respect to the provisions relating to the health insurance providers fee imposed by section 9010 of the Affordable Care Act, Rachel Smith, at 202–317–6855; with respect to the definition of expatriate health plans, expatriate health insurance issuers, and qualified expatriates, and the provisions relating to the market reforms (such as excepted benefits, and short-term, limited-duration coverage), R. Lisa Mojiri-Azad of the IRS Office of Chief Counsel, at 202–317–5500, Elizabeth Schumacher or Matthew Litton of the Department of Labor, at 202–693–8335, Jacob Ackerman of the Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 301–492–4179. Concerning the submission of comments or to request a public hearing, Regina Johnson. (202) 317–6901 (not toll-free numbers).

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline, at 1–866–444–EBSA (3272) or visit the Department of Labor's Web site (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (*www.cms.gov/cciio*) and information on health reform can be found at *www.HealthCare.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

This document contains proposed amendments to Department of the Treasury (Treasury Department) regulations at 26 CFR part 1 (Income taxes), 26 CFR part 46 (Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements), 26 CFR part 54 (Pension and excise taxes), 26 CFR part 57 (Health insurance providers fee), and 26 CFR part 301 (relating to procedure and administration) to implement the rules for expatriate health plans, expatriate health plan issuers, and qualified expatriates under the Expatriate Health Coverage Clarification Act of 2014 (EHCCA), which was enacted as Division M of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113–235 (128 Stat. 2130). This document also contains proposed amendments to DOL regulations at 29 CFR part 2590 and HHS regulations at 45 CFR part 147, which are substantively identical to the amendments to 26 CFR part 54.

The EHCCA generally provides that the requirements of the Affordable Care Act [1] (ACA) do not apply with respect to expatriate health plans, expatriate health insurance issuers for coverage under expatriate health plans, and employers in their capacity as plan sponsors of expatriate health plans, except that: (1) An expatriate health plan shall be treated as minimum essential coverage under section

[1] The Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111–152, was enacted on March 30, 2010. They are collectively known as the ''Affordable Care Act.''

5000A(f) of the Internal Revenue Code of 1986, as amended (the Code) and any other section of the Code that incorporates the definition of minimum essential coverage; (2) the employer shared responsibility provisions of section 4980H of the Code continue to apply; (3) the health care reporting provisions of sections 6055 and 6056 of the Code continue to apply but with certain modifications relating to the use of electronic media for required statements to enrollees; (4) the excise tax provisions of section 4980I of the Code continue to apply with respect to coverage of certain qualified expatriates who are assigned (rather than transferred) to work in the United States; and (5) the annual health insurance providers fee imposed by section 9010 of the ACA takes into account expatriate health insurance issuers for certain purposes for calendar years 2014 and 2015 only.

This document also contains proposed amendments to 26 CFR part 54, 29 CFR part 2590, and 45 CFR parts 146 and 148, which would specify conditions for travel insurance, supplemental health insurance coverage, and hospital indemnity and other fixed indemnity insurance to be considered excepted benefits. Excepted benefits are exempt from the requirements that generally apply under title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), and Chapter 100 of the Code. In addition, this document contains proposed amendments to (1) the definition of ''short-term, limited-duration insurance,'' for purposes of the exclusion from the definition of ''individual health insurance coverage'' and (2) the definition of ''essential health benefits,'' for purposes of the prohibition on annual and lifetime dollar limits in 26 CFR part 54, 29 CFR 2590, and 45 CFR parts 144 and 147.

This document clarifies an exemption set forth in 45 CFR 153.400(a)(1)(iii) related to the transitional reinsurance program. Section 1341 of the Affordable Care Act provides for the establishment of a transitional reinsurance program in each State to help pay the cost of treating high-cost enrollees in the individual market in the 2014 through 2016 benefit years. Section 1341(b)(3)(B) of the ACA and 45 CFR 153.400(a)(1) require contributing entities to make reinsurance contributions for major medical coverage that is considered to be part of a commercial book of business.

This document also contains proposed conforming amendments to 45 CFR part 158 that address the separate medical loss ratio (MLR) reporting requirements for expatriate policies that are not expatriate health plans under the EHCCA.

General Statutory Background and Enactment of ACA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191 (110 Stat. 1936), added title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code, which impose portability and nondiscrimination rules with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other consumer protection laws, including the Mental Health Parity Act of 1996, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Genetic Information Nondiscrimination Act of 2008, the Children's Health Insurance Program Reauthorization Act of 2009, Michelle's Law, and the ACA.

The ACA reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. For this purpose, the term ''group health plan'' includes both insured and self-insured group health plans.[2] The ACA added section 715(a)(1) of ERISA and section 9815(a)(1) of the Code to incorporate the provisions of part A of title XXVII of the PHS Act (generally, sections 2701 through 2728 of the PHS Act) into ERISA and the Code to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans.

Expatriate Health Plans, Expatriate Health Plan Issuers and Qualified Expatriates

Prior to the enactment of the EHCCA, employers, issuers and covered individuals had expressed concerns about the application of the ACA market reform rules to expatriate health plans and whether coverage under expatriate health plans was minimum essential coverage for purposes of section 5000A of the Code. To address these concerns on an interim basis, on March 8, 2013, the Departments of Labor, HHS, and the Treasury (collectively, the Departments [3]) issued Affordable Care Act Implementation Frequently Asked Questions (FAQs) Part XIII, Q&A–1, providing relief from the ACA market reform requirements for certain expatriate group health insurance coverage.[4] For plan years ending on or before December 31, 2015, the FAQ provides that, with respect to expatriate health plans, the Departments will consider the requirements of subtitles A and C of title I of the ACA to be satisfied if the plan and issuer comply with the pre-ACA version of title XXVII of the PHS Act. For purposes of the relief, an expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage. The FAQ also states that coverage provided under an expatriate group health plan is a form of minimum essential coverage under section 5000A of the Code. On January 9, 2014, the Departments issued Affordable Care Act Implementation FAQs Part XVIII, Q&A–6 and Q&A–7, which extended the relief of Affordable Care Act Implementation FAQs Part XIII, Q&A–1 for insured expatriate health plans to subtitle D of title I of the ACA and also provided that the relief from the requirements of subtitles A, C, and D of title I of the ACA would apply for plan years ending on or before December 31, 2016.[5]

Subsequently, the EHCCA was enacted on December 16, 2014. Section 3(a) of the EHCCA provides that the ACA generally does not apply to expatriate health plans, employers with respect to expatriate health plans but solely in their capacity as plan sponsors of these plans, and expatriate health insurance issuers with respect to coverage offered by such issuers under expatriate health plans. Under section 3(b) of the EHCCA, however, the ACA continues to apply to expatriate health plans with respect to the employer shared responsibility provisions of section 4980H of the Code, the reporting requirements of sections 6055 and 6056

[2] The term ''group health plan'' is used in title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code, and is distinct from the term ''health plan,'' as used in other provisions of title I of the ACA. The term ''health plan'' does not include self-insured group health plans.

[3] Note, however, that in sections under headings listing only two of the three Departments, the term ''Departments'' generally refers only to the two Departments listed in the heading.

[4] Frequently Asked Questions about Affordable Care Act Implementation (Part XIII), available at *http://www.dol.gov/ebsa/pdf/faq-aca13.pdf* and *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-andFAQs/ACA_implementation_faq13.html.*

[5] Frequently Asked Questions about Affordable Care Act Implementation (Part XVIII), available at *https://www.dol.gov/ebsa/faqs/faq-aca18.html* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html.*

of the Code, and the excise tax provisions of section 4980I of the Code. Section 3(b) of the EHCCA further provides that an expatriate health plan offered to primary enrollees described in sections 3(d)(3)(A) and (B) of the EHCCA shall be treated as an eligible employer sponsored plan under section 5000A(f)(2) of the Code, and that an expatriate health plan offered to primary enrollees described in section 3(d)(3)(C) of the EHCCA shall be treated as a plan in the individual market under section 5000A(f)(1)(C) of the Code. Section 3(c) of the EHCCA sets forth rules for expatriate health plans with respect to the annual health insurance providers fee imposed by section 9010 of the ACA.

Sections 4375 and 4376 of the Code impose the Patient-Centered Outcomes Research Trust Fund (PCORTF) fee only with respect to individuals residing in the United States. Final regulations regarding the PCORTF fee exempt any specified health insurance policy or applicable self-insured group health plan designed and issued specifically to cover employees who are working and residing outside the United States from the fee. The exclusion from the ACA for expatriate health plans, employers with respect to expatriate health plans but solely in their capacity as plan sponsors of these plans, and expatriate health insurance issuers with respect to coverage offered by such issuers under expatriate health plans would apply to the PCORTF fee to the extent an expatriate health plan was not already excluded from the fee.

Section 1341 of the ACA establishes a transitional reinsurance program to help stabilize premiums for non-grandfathered health insurance coverage in the individual health insurance market from 2014 through 2016. Section 1341(b)(3)(B) of the ACA and the implementing regulations at 45 CFR 153.400(a)(1) require health insurance issuers and certain self-insured group health plans (''contributing entities'') to make reinsurance contributions for major medical coverage that is considered to be part of a commercial book of business. This language has been interpreted to exclude ''expatriate health coverage.'' [6] As such, HHS regulation at 45 CFR 153.400(a)(1)(iii) provides that a contributing entity must make reinsurance contributions for lives covered by its self-insured group health plans and health insurance coverage, except to the extent that such plan or coverage is expatriate health coverage, as defined by the Secretary of HHS, or for the 2015 and 2016 benefit years only, is a self-insured group health plan with respect to which enrollment is limited to participants who reside outside of their home country for at least six months of the plan year and any covered dependents of such participants. As noted in the March 8, 2013 Affordable Care Act Implementation FAQs Part XIII, Q&A–1, the FAQ definition of ''expatriate health plan'' was extended to the definition of ''expatriate health coverage'' under 45 CFR 153.400(a)(1)(iii).

Section 3(a) of the EHCCA provides that the ACA generally does not apply to expatriate health plans, employers with respect to expatriate health plans but solely in their capacity as plan sponsors of expatriate health plans, and expatriate health insurance issuers with respect to coverage offered by such issuers under expatriate health plans. Accordingly, under the EHCCA, the transitional reinsurance program contribution obligation under section 1341 of the ACA does not apply to expatriate health plans.

Section 5000A of the Code, as added by section 1501 of the ACA, provides that, for each month, taxpayers must have minimum essential coverage, qualify for a health coverage exemption, or make an individual shared responsibility payment when filing a federal income tax return. Section 5000A(f)(1)(B) of the Code provides that minimum essential coverage includes coverage under an eligible employer-sponsored plan. Section 5000A(f)(2) of the Code and 26 CFR 1.5000A–2(c) provide that an eligible employer-sponsored plan means, with respect to an employee, group health insurance coverage that is a governmental plan or any other plan or coverage offered in the small or large group market within a State, or a self-insured group health plan. Under section 5000A(f)(1)(C) of the Code, minimum essential coverage includes coverage under a health plan offered in the individual market within a State.

Section 3(b)(1)(A) of the EHCCA provides that an expatriate health plan that is offered to primary enrollees who are qualified expatriates described in sections 3(d)(3)(A) and 3(d)(3)(B) of the EHCCA is treated as an eligible employer-sponsored plan within the meaning of section 5000A(f)(2) of the Code. Section 3(b)(1)(B) of the EHCCA provides that, in the case of an expatriate health plan that is offered to primary enrollees who are qualified expatriates described in section 3(d)(3)(C) of the EHCCA, the coverage is treated as a plan in the individual market within the meaning of section 5000A(f)(1)(C) of the Code, for purposes of sections 36B, 5000A and 6055 of the Code.

Under section 6055 of the Code, as added by section 1502 of the ACA, providers of minimum essential coverage must file an information return with the Internal Revenue Service (IRS) and furnish a written statement to covered individuals reporting the months that an individual had minimum essential coverage. Under section 6056 of the Code, as added by section 1514 of the ACA, an applicable large employer (as defined in section 4980H(c)(2) of the Code and 26 CFR 54.4980H–1(a)(4) and 54.4980H–2) must file an information return with the IRS and furnish a written statement to its full-time employees reporting details regarding the minimum essential coverage, if any, offered by the employer. Under both sections 6055 and 6056 of the Code, reporting entities may satisfy the requirement to furnish statements to covered individuals and employees, respectively, by electronic means only if the individual or employee affirmatively consents to receiving the statements electronically.[7]

Under section 4980H of the Code, as added by section 1513 of the ACA, an applicable large employer that does not offer minimum essential coverage to its full-time employees (and their dependents) or offers minimum essential coverage that does not meet the standards for affordability and minimum value will owe an assessable payment if a full-time employee is certified as having enrolled in a qualified health plan on an Exchange with respect to which a premium tax credit is allowed with respect to the employee.

Section 3(b)(2) of the EHCCA provides that the reporting requirements of sections 6055 and 6056 of the Code and the provisions of section 4980H of the Code relating to the employer shared responsibility provisions for applicable large employers continue to apply with respect to expatriate health plans and qualified expatriates. Section 3(b)(2) of the EHCCA provides a special rule for the use of electronic media for statements required under sections 6055 and 6056 of the Code. Specifically, the required statements may be provided to a primary insured for coverage under an expatriate health plan using electronic media unless the primary insured has explicitly refused to consent to receive the statement electronically.

[6] See HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15410) (March 11, 2013) and HHS Notice of Benefit and Payment Parameters for 2016 (80 FR 10750) (February 27, 2015).

[7] See 26 CFR 1.6055–2(a)(2)(i) and 301.6056–2(a)(2)(i).

Section 4980I of the Code, as added by section 9001 of the ACA, imposes an excise tax if the aggregate cost of applicable employer-sponsored coverage provided to an employee exceeds a statutory dollar limit. Section 3(b)(2) of the EHCCA provides that section 4980I of the Code continues to apply to applicable employer-sponsored coverage (as defined in section 4980I(d)(1) of the Code) of a qualified expatriate (as described in section 3(d)(3)(A)(i) of the EHCCA) who is assigned (rather than transferred) to work in the United States.

Section 9010 of the ACA imposes a fee on covered entities engaged in the business of providing health insurance for United States health risks. Section 3(c)(1) of the EHCCA excludes expatriate health plans from the health insurance providers fee imposed by section 9010 of the ACA by providing that, for calendar years after 2015, a qualified expatriate (and any spouse, dependent, or any other individual enrolled in the plan) enrolled in an expatriate health plan is not considered a United States health risk. Section 3(c)(2) of the EHCCA provides a special rule solely for purposes of determining the health insurance providers fee imposed by section 9010 of the ACA for the 2014 and 2015 fee years.

Section 162(m)(6) of the Code, as added by section 9014 of the ACA, in general, limits to $500,000 the allowable deduction for remuneration attributable to services performed by certain individuals for a covered health insurance provider. For taxable years beginning after December 31, 2012, section 162(m)(6)(C)(i) of the Code and 26 CFR 1.162–31(b)(4)(A) provide that a health insurance issuer is a covered health insurance provider if not less than 25 percent of the gross premiums that it receives from providing health insurance coverage during the taxable year are from minimum essential coverage. Section 3(a)(3) of the EHCCA provides that the provisions of the ACA (including section 162(m)(6) of the Code) do not apply to expatriate health insurance issuers with respect to coverage offered by such issuers under expatriate health plans.

Section 3(d)(2) of the EHCCA provides that an expatriate health plan means a group health plan, health insurance coverage offered in connection with a group health plan, or health insurance coverage offered to certain groups of similarly situated individuals, provided that the plan or coverage meets a number of specific requirements. Section 3(d)(2)(A) of the EHCCA provides that substantially all of the primary enrollees of an expatriate health plan must be qualified expatriates. For this purpose, primary enrollees do not include individuals who are not nationals of the United States and reside in the country of their citizenship. Section 3(d)(2)(B) of the EHCCA provides that substantially all of the benefits provided under a plan or coverage must be benefits that are not excepted benefits. Section 3(d)(2)(C) of the EHCCA provides that the plan or coverage must provide coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services that are comparable to the emergency services coverage that was described in or offered under 5 U.S.C. 8903(1) for the 2009 plan year.[8] Also, coverage for these services must be provided in certain countries. For qualified expatriates described in section 3(d)(3)(A) of the EHCCA (category A) and qualified expatriates described in section 3(d)(3)(B) of the EHCCA (category B), coverage for these services must be provided in the country or countries where the individual is working, and such other country or countries as the Secretary of HHS, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate. For qualified expatriates who are members of a group of similarly situated individuals described in section 3(d)(3)(C) of the EHCCA (category C), the coverage must be provided in the country or countries that the Secretary of HHS, in consultation with the Secretary of the Treasury and the Secretary of Labor, may designate.

Section 3(d)(2)(D) of the EHCCA provides that a plan qualifies as an expatriate health plan under the EHCCA only if the plan sponsor reasonably believes that benefits under the plan satisfy a standard at least actuarially equivalent to the level provided for in section 36B(c)(2)(C)(ii) of the Code (that is, ''minimum value''). Section 3(d)(2)(E) of the EHCCA provides that dependent coverage of children, if offered under the expatriate health plan, must continue to be available until the individual attains age 26 (unless the individual is the child of a child receiving dependent coverage). Section 3(d)(2)(G) of the EHCCA provides that an expatriate health plan must satisfy the provisions of title XXVII of the PHS Act, Chapter 100 of the Code, and part 7 of subtitle B of title I of ERISA, that would otherwise apply if the ACA had not been enacted. These provisions are sometimes referred to as the HIPAA portability and nondiscrimination requirements.

Section 3(d)(1) of the EHCCA provides that an expatriate health insurance issuer means a health insurance issuer that issues expatriate health plans. Section 3(d)(2)(F)(i) of the EHCCA provides that an expatriate health plan or coverage must be issued by an expatriate health plan issuer, or administered by an administrator, that together with any person in the issuer's or administrator's controlled group: (1) Maintains network provider agreements that provide for direct claims payments (directly or through third-party contracts), with health care providers in eight or more countries; (2) maintains call centers (directly or through third-party contracts) in three or more countries and accepts calls in eight or more languages; (3) processes at least $1 million in claims in foreign currency equivalents each year; (4) makes global evacuation/repatriation coverage available; (5) maintains legal and compliance resources in three or more countries; and (6) has licenses to sell insurance in more than two countries. In addition, section 3(d)(2)(F)(ii) of the EHCCA provides that the plan or coverage must offer reimbursement for items or services under such plan or coverage in the local currency in eight or more countries.

Section 3(d)(3) of the EHCCA describes three categories of qualified expatriates. A category A qualified expatriate, under section 3(d)(3)(A) of the EHCCA, is 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 or assignment tied to the individual's employment and who the plan sponsor has reasonably determined requires access to health insurance and other related services and support in multiple countries, and is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross-border moving expenses, or compensation to enable the expatriate to return to the expatriate's home country). A category B qualified expatriate, under section 3(d)(3)(B) of the EHCCA, is a primary insured who is working outside the United States for at least 180 days during a consecutive 12-month period that overlaps with the plan year. A category C qualified expatriate, under section 3(d)(3)(C) of the EHCCA, is an individual who is a member of a group of similarly situated individuals that is formed for the

[8] These are emergency services comparable to emergency services offered under a government-wide comprehensive health plan under the Federal Employees Health Benefits (FEHB) program prior to the enactment of the ACA.

purpose of traveling or relocating internationally in service of one or more of the purposes listed in section 501(c)(3) or (4) of the Code, or similarly situated organizations or groups, provided the group is not formed primarily for the sale of health insurance coverage and the Secretary of HHS, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines the group requires access to health insurance and other related services and support in multiple countries.

Section 3(d)(4) of the EHCCA defines the United States as the 50 States, the District of Columbia, and Puerto Rico.

Section 3(f) of the EHCCA provides that, unless otherwise specified, the requirements of the EHCCA apply to expatriate health plans issued or renewed on or after July 1, 2015.

IRS Notice 2015–43

On July 20, 2015, the Treasury Department and the IRS issued Notice 2015–43 (2015–29 IRB 73) to provide interim guidance on the implementation of the EHCCA and the application of certain provisions of the ACA to expatriate health insurance issuers, expatriate health plans, and employers in their capacity as plan sponsors of expatriate health plans. The Departments of Labor and HHS reviewed and concurred with the interim guidance of Notice 2015–43. Comments were received in response to Notice 2015–43, and these comments have been considered in drafting these proposed regulations. The relevant portions of Notice 2015–43 and the related comments are discussed in the Overview of Proposed Regulations section of this preamble.[9]

IRS Notices 2015–29 and 2016–14

On March 30, 2015, the Treasury Department and the IRS issued Notice 2015–29 (2015–15 IRB 873) to provide guidance implementing the special rule of section 3(c)(2) of the EHCCA for fee years 2014 and 2015 with respect to the health insurance providers fee imposed by section 9010 of the ACA. Notice 2015–29 defines expatriate health plan by reference to the definition of expatriate policies in the MLR final rule issued by HHS [10] (MLR final rule definition) solely for the purpose of applying the special rule for fee years 2014 and 2015. The Treasury Department and the IRS determined that the MLR final rule definition of expatriate policies was sufficiently broad to cover potential expatriate health plans described in section 3(d)(2) of the EHCCA. The MLR final rule defines expatriate policies as predominantly group health insurance policies that provide coverage to employees, substantially all of whom are: (1) Working outside their country of citizenship; (2) working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in their home country.

On January 29, 2016, the Treasury Department and the IRS issued Notice 2016–14 (2016–7 IRB 315) to provide guidance implementing the definition of expatriate health plan for fee year 2016 with respect to the health insurance providers fee imposed by section 9010 of the ACA. Like Notice 2015–29, Notice 2016–14 provides that the definition of expatriate health plan will be the same as provided in the MLR final rule definition, solely for the purpose of the health insurance providers fee imposed by section 9010 of the ACA for fee year 2016.[11]

The Consolidated Appropriations Act, 2016, Public Law 114–113, Division P, Title II, § 201, Moratorium on Annual Fee on Health Insurance Providers (the Consolidated Appropriations Act), suspends collection of the health insurance providers fee for the 2017 calendar year. Thus, health insurance issuers are not required to pay the fee for 2017.

Excepted Benefits

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to the provision of certain types of benefits, known as ''excepted benefits.'' These excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code.

There are four statutorily enumerated categories of excepted benefits. One category, under section 2791(c)(1) of the PHS Act, section 733(c)(1) of ERISA, and section 9832(c)(1) of the Code, identifies benefits that are excepted in all circumstances, including automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage. Under section 2791(c)(1)(H) of the PHS Act (and the parallel provisions of ERISA and the Code), this category of excepted benefits also includes ''[o]ther similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.''

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of HHS, Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements.[12] To be an excepted benefit under this second category, the statute provides that these limited benefits must either: (1) Be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.[13]

The third category of excepted benefits, referred to as ''noncoordinated excepted benefits,'' includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. These benefits are excepted under section 2722(c)(2) of the PHS Act, section 732(c)(2) of ERISA, and section 9831(c)(2) of the Code only if all of the following conditions are met: (1) The benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor. In the group market, the regulations further provide that to be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.[14]

Since the issuance of these regulations, the Departments have released FAQs to address various requests for clarification as to what types of coverage meet the conditions

[9] See 26 CFR 601.601(d)(2)(ii)(B).

[10] 45 CFR 158.120(d)(4).

[11] See 26 CFR 601.601(d)(2)(ii)(B).

[12] 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), 45 CFR 146.145(b)(3)(v).

[13] PHS Act section 2722(c)(1), ERISA section 732(c)(1), Code section 9831(c)(1).

[14] 26 CFR 54.9831–1(c)(4)(i), 29 CFR 2590.732(c)(4)(i), 45 CFR 146.145(b)(4)(i).

necessary to be hospital indemnity or other fixed indemnity insurance that are excepted benefits. Affordable Care Act Implementation FAQs Part XI, Q&A–7 clarified that group health insurance coverage in which benefits are provided in varying amounts based on the type of procedure or item, such as the type of surgery actually performed or prescription drug provided is not a hospital indemnity or other fixed indemnity insurance excepted benefit because it does not meet the condition that benefits be provided on a per day (or per other time period, such as per week) basis, regardless of the amount of expenses incurred.[15]

The fourth category, under section 2791(c)(4) of the PHS Act, section 733(c)(4) of ERISA, and section 9832(c)(4) of the Code, is supplemental excepted benefits. Benefits are supplemental excepted benefits only if they are provided under a separate policy, certificate, or contract of insurance and are Medicare supplemental health insurance (also known as Medigap), TRICARE supplemental programs, or ''similar supplemental coverage provided to coverage under a group health plan.'' The phrase ''similar supplemental coverage provided to coverage under a group health plan'' is not defined in the statute or regulations. However, the Departments' regulations clarify that one requirement to be similar supplemental coverage is that the coverage ''must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles.'' [16]

In 2007 and 2008, the Departments issued guidance on the circumstances under which supplemental health insurance would be considered excepted benefits under section 2791(c)(4) of the PHS Act (and the parallel provisions of ERISA, and the Code).[17] The guidance identifies several factors the Departments will apply when evaluating whether supplemental health insurance will be considered to be ''similar supplemental coverage provided to coverage under a group health plan.'' Specifically the Departments' guidance provides that supplemental health insurance will be considered an excepted benefit if it is provided through a policy, certificate, or contract of insurance separate from the primary coverage under the plan and meets all of the following requirements: (1) The supplemental policy, certificate, or contract of insurance is issued by an entity that does not provide the primary coverage under the plan; (2) the supplemental policy, certificate, or contract of insurance is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination of benefits provision; (3) the cost of the supplemental coverage is 15 percent or less of the cost of primary coverage (determined in the same manner as the applicable premium is calculated under a COBRA continuation provision); and (4) the supplemental coverage sold in the group health insurance market does not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual (or any dependents of the individual).

On February 13, 2015, the Departments issued Affordable Care Act Implementation FAQs Part XXIII, providing additional guidance on the circumstances under which health insurance coverage that supplements group health plan coverage may be considered supplemental excepted benefits.[18] The FAQ states that the Departments intend to propose regulations clarifying the circumstances under which supplemental insurance products that do not fill in cost-sharing under the primary plan are considered to be specifically designed to fill gaps in primary coverage. Specifically, the FAQ provides that health insurance coverage that supplements group health coverage by providing coverage of additional categories of benefits (as opposed to filling in cost-sharing gaps under the primary plan) would be considered to be designed to ''fill in the gaps'' of the primary coverage only if the benefits covered by the supplemental insurance product are not essential health benefits (EHB) in the State in which the product is being marketed. The FAQ further states that, until regulations are issued and effective, the Departments will not take enforcement action under certain conditions for failure to comply with the applicable insurance market reforms with respect to group or individual health insurance coverage that provides coverage of additional categories of benefits that are not EHBs in the applicable State. States were encouraged to exercise similar enforcement discretion.

Short-Term, Limited-Duration Insurance Coverage

Short-term limited duration insurance is a type of health insurance coverage that is designed to fill in temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage. Although short-term, limited-duration insurance is not an excepted benefit, it is similarly exempt from PHS Act requirements because it is not individual health insurance coverage. Section 2791(b)(5) of the PHS Act provides that the term ''individual health insurance coverage'' means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. The PHS Act does not define short-term, limited-duration insurance. Under existing regulations, short-term, limited-duration insurance means ''health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.'' [19]

Prohibition on Lifetime and Annual Limits

Section 2711 of the PHS Act, as added by the ACA, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime and annual dollar limits on EHB, as defined in section 1302(b) of the ACA. These prohibitions apply to both grandfathered and non-grandfathered health plans, except the annual limits prohibition does not apply to grandfathered individual health insurance coverage.

Under the ACA, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB, but they generally cannot place lifetime or annual dollar limits on covered services that are considered EHB. The Departments' regulations provide that, for plan years (in the individual market, policy years) beginning on or after January 1, 2017, a plan or issuer that is

[15] Frequently Asked Questions about Affordable Care Act Implementation (Part XI), available at *http://www.dol.gov/ebsa/faqs/faq-aca11.html* and *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html*.

[16] 26 CFR 54.9831–1(c)(5)(i)(C), 29 CFR 2590.732(c)(5)(i)(C), and 45 CFR 146.145(b)(5)(i)(C).

[17] See EBSA Field Assistance Bulletin No. 2007–04 (available at *http://www.dol.gov/ebsa/regs/fab2007-4.html*); CMS Insurance Standards Bulletin 08–01 (available at *http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf*); and IRS Notice 2008–23 (available at *http://www.irs.gov/irb/2008-07_IRB/ar09.html*).

[18] Frequently Asked Questions about Affordable Care Act Implementation (Part XXIII), available at *http://www.dol.gov/ebsa/pdf/faq-aca23.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Supplmental-FAQ_2-13-15-final.pdf*.

[19] 26 CFR 54.9801–2, 29 CFR 2590.701–2, 45 CFR 144.103.

not required to provide EHB may select from among any of the 51 base-benchmark plans selected by a State or applied by default pursuant to 45 CFR 156.100, or one of the three FEHBP options specified at 45 CFR 156.100(a)(3), for purposes of complying with the lifetime and annual limits prohibition in section 2711 of the PHS Act.[20]

II. Overview of the Proposed Regulations

A. Expatriate Health Plans

In General

Section 3(a) of the EHCCA provides that the ACA generally does not apply to expatriate health plans, employers with respect to expatriate health plans but solely in their capacity as plan sponsors of expatriate health plans, and expatriate health insurance issuers with respect to coverage offered by such issuers under expatriate health plans. Consistent with this provision, the proposed regulations provide that the market reform provisions enacted or amended as part of the ACA, included in sections 2701 through 2728 of the PHS Act and incorporated into section 9815 of the Code and section 715 of ERISA, do not apply to an expatriate health plan, an employer, solely in its capacity as plan sponsor of an expatriate health plan, and an expatriate health insurance issuer with respect to coverage under an expatriate health plan. Similarly, section 162(m)(6) of the Code does not apply to an expatriate health insurance issuer with respect to premiums received for coverage under an expatriate health plan. In addition, under the EHCCA, the PCORTF fee under sections 4375 and 4376 of the Code and the transitional reinsurance program fee under section 1341 of the ACA do not apply to expatriate health plans. The EHCCA excludes expatriate health plans from the health insurance providers fee imposed by section 9010 except that the EHCCA provides a special rule solely for purposes of determining the fee for the 2014 and 2015 fee years. The EHCCA also designates certain coverage by an expatriate health plan as minimum essential coverage under section 5000A(f) of the Code, and provides special rules for the application of the reporting rules under sections 6055 and 6056 of the Code to expatriate health plans.

[20] 26 CFR 54.9815–2711(c), 29 CFR 2590.715–2711(c), 45 CFR 147.126(c).

Definition of Expatriate Health Insurance Issuer

Consistent with sections 3(d)(1) and (d)(2)(F) of the EHCCA, the proposed regulations define ''expatriate health insurance issuer'' as a health insurance issuer (as defined under 26 CFR 54.9801–2, 29 CFR 2590.701–2 and 45 CFR 144.103) that issues expatriate health plans and satisfies certain requirements.[21] The requirements for the issuer to be an expatriate health insurance issuer include that, in the course of its normal business operations, the issuer: (1) Maintains network provider agreements that provide for direct claims payments with health care providers in eight or more countries; (2) maintains call centers in three or more countries, and accepts calls from customers in eight or more languages; (3) processed at least $1 million in claims in foreign currency equivalents during the preceding calendar year; (4) makes global evacuation/repatriation coverage available; (5) maintains legal and compliance resources in three or more countries; and (6) has licenses or other authority to sell insurance in more than two countries, including the United States. For purposes of meeting the $1 million threshold for claims processed in foreign currency equivalents, the proposed regulations provide that the dollar value of claims processed is determined using the Treasury Department's currency exchange rate in effect on the last day of the preceding calendar year.[22] Comments are requested regarding whether use of the calendar year as the basis for measuring the dollar amount of claims processed presents administrative challenges, and how the resulting challenges, if any, may be addressed. The proposed regulations provide that each of the applicable requirements may be satisfied by two or more entities (including one entity that is the health insurance issuer) that are members of the health insurance issuer's controlled group or through contracts between the expatriate health insurance issuer and third parties.

[21] Section 3(d)(1) of the EHCCA provides that the term ''expatriate health insurance issuer'' means a health insurance issuer that issues expatriate health plans; section 3(d)(5)(A) of the EHCCA provides that the term ''health insurance issuer'' has the meaning given in section 2791 of the PHS Act. The definition of health insurance issuer in section 9832(b)(2) of the Code and section 733(b)(2) of ERISA and underlying regulations are substantively identical to the definition under section 2791 of the PHS Act and its underlying regulations.

As discussed in the section of this preamble entitled ''Definition of Expatriate Health Plan'' a health insurance issuer as defined in section 2791 of the PHS Act is limited to an entity licensed to engage in the business of insurance in a State and subject to State law that regulates insurance.

[22] The most recent Treasury Department currency exchange rate can be found at *https://www.fiscal.treasury.gov/fsreports/rpt/treasRptRateExch/currentRates.htm.*

Definition of Expatriate Health Plan

Consistent with section 3(d)(2) of the EHCCA, the proposed regulations define ''expatriate health plan'' as a plan offered to qualified expatriates and that satisfies certain requirements. With respect to qualified expatriates in categories A or B, the plan must be a group health plan (whether or not insured). In contrast, with respect to qualified expatriates in category C, the plan must be health insurance coverage that is not a group health plan. In addition, consistent with section 3(d)(2)(A) of the EHCCA, the proposed regulations require that substantially all primary enrollees in the expatriate health plan must be qualified expatriates. The proposed regulations define a primary enrollee as the individual covered by the plan or policy whose eligibility for coverage is not due to that individual's status as the spouse, dependent, or other beneficiary of another covered individual. However, notwithstanding this definition, an individual is not a primary enrollee if the individual is not a national of the United States and the individual resides in his or her country of citizenship. Further, the proposed regulations provide that, for this purpose, a ''national of the United States'' has the meaning used in the Immigration and Nationality Act (8 U.S.C. 1101 et. seq.) and 8 CFR parts 301 to 392, including U.S. citizens. Thus, for example, an individual born in American Samoa is a national of the United States at birth for purposes of the EHCCA and the proposed regulations.

Comments in response to Notice 2015–43 requested clarification of the ''substantially all'' enrollment requirement, with one comment suggesting that 93 percent of the enrollees would be an appropriate threshold. In response to the request for clarification, the proposed regulations provide that a plan satisfies the ''substantially all'' enrollment requirement if, on the first day of the plan year, less than 5 percent of the primary enrollees (or less than 5 primary enrollees if greater) are not qualified expatriates (effectively a 95 percent threshold). Consistent with section 3(d)(2)(B) of the EHCCA, the proposed regulations further provide that substantially all of the benefits provided under an expatriate health plan must be benefits that are not excepted benefits as described in 26

CFR 54.9831–1(c), 29 CFR 2590.732(c), 45 CFR 146.145(b) and 148.220, as applicable. The Departments intend that the first day of the plan year approach, which has been used in other contexts, will be simple to administer.[23] Moreover, the 95% threshold has been used in certain other circumstances in applying a ''substantially all'' standard.[24] The Departments solicit comment on this regulatory approach and whether the current regulatory language is sufficient to protect against potential abuses, or whether any further anti-abuse provision is necessary.

Consistent with section 3(d)(2)(C) of the EHCCA, the proposed regulations also require that an expatriate health plan cover certain types of services. Specifically, an expatriate health plan must provide coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services (comparable to emergency services coverage that was described in and offered under section 8903(1) of title 5, United States Code for plan year 2009). Coverage for such services must be available in certain countries depending on the type of qualified expatriates covered by the plan. The statute authorizes the Secretary of HHS, in consultation with the Secretary of the Treasury and Secretary of Labor, to designate other countries where coverage for such services must be made available to the qualified expatriate.

Consistent with section 3(d)(2)(D) of the EHCCA, the proposed regulations provide that in the case of an expatriate health plan, the plan sponsor must reasonably believe that benefits provided by the plan satisfy the minimum value requirements of section 36B(c)(2)(C)(ii) of the Code.[25] For this purpose, the proposed regulations provide that the plan sponsor is permitted to rely on the reasonable representations of the issuer or administrator regarding whether benefits offered by the group health plan or issuer satisfy the minimum value requirements unless the plan sponsor knows or has reason to know that the benefits fail to satisfy the minimum value requirements. Consistent with section 3(d)(2)(D) of the EHCCA, in the case of an expatriate health plan that provides dependent coverage of children, the proposed regulations provide that such coverage must be available until the individual attains age 26, unless the individual is the child of a child receiving dependent coverage. Additionally, consistent with section 3(d)(2)(F)(ii) of the EHCCA, the plan or coverage must offer reimbursements for items or services in the local currency in eight or more countries.

Consistent with section 3(d)(2)(F) of the EHCCA, the proposed regulations also provide that the policy or coverage under an expatriate health plan must be issued by an expatriate health insurance issuer or administered by an expatriate health plan administrator. With respect to qualified expatriates in categories A or B (generally, individuals whose travel or relocation is related to their employment with an employer), the coverage must be under a group health plan (whether insured or self-insured). With respect to qualified expatriates in category C (generally, groups of similarly situated individuals travelling for certain tax-exempt purposes), the coverage must be under a policy issued by an expatriate health insurance issuer.

Finally, consistent with section 3(d)(2)(G) of the EHCCA, the proposed regulations provide that an expatriate health plan must satisfy the provisions of Chapter 100 of the Code, part 7 of subtitle B of title I of ERISA and title XXVII of the PHS Act that would otherwise apply if the ACA had not been enacted. Among other requirements, those provisions limited the ability of a group health plan or group health insurance issuer to impose preexisting condition exclusions (which are now prohibited for grandfathered and non-grandfathered group health plans and health insurance coverage offered in connection with such plans, and non-grandfathered individual health insurance coverage under the ACA), including a requirement that the period of any preexisting condition exclusion be reduced by the length of any period of creditable coverage the individual had without a 63-day break in coverage.

Prior to the enactment of the ACA, HIPAA and underlying regulations also generally required that plans and issuers provide certificates of creditable coverage when an individual ceased to be covered by a plan or policy and upon request. Following the enactment of the ACA, the regulations under these provisions have eliminated the requirement for providing certificates of creditable coverage beginning December 31, 2014, because the requirement is generally no longer relevant to plans and participants as a result of the prohibition on preexisting condition exclusions. The Departments recognize that reimposing the requirement to provide certificates of creditable coverage on expatriate health plans would only be useful in situations in which an individual transferred from one expatriate health plan to another and that reimposing the requirement on all health plans would require certificates that would be unnecessary except in limited cases, such as for an individual who ceased coverage with a health plan or policy and began coverage under an expatriate health plan that imposed a preexisting condition exclusion. Because reimposing the requirement to provide certificates of creditable coverage would be inefficient and overly broad, and relevant in only limited circumstances, the proposed regulations do not require expatriate health plans to provide certificates of creditable coverage. However, expatriate health plans imposing a preexisting condition exclusion must still comply with certain limitations on preexisting condition exclusions that would otherwise apply if the ACA had not been enacted. Therefore, the proposed regulations require expatriate health plans to ensure that individuals who enroll in the expatriate health plan are provided an opportunity to demonstrate creditable coverage to offset any preexisting condition exclusion. For example, an email from the prior issuer (or former plan administrator or plan sponsor) providing information about past coverage could be sufficient confirmation of prior creditable coverage.

Comments in response to Notice 2015–43 requested clarification of the treatment of health coverage provided by a foreign government. Specifically, comments requested that health coverage provided by a foreign government be treated as minimum essential coverage under section 5000A of the Code, and that, for purposes of the employer shared responsibility provision of section 4980H of the Code, an offer of such coverage be treated as an offer of minimum essential coverage for certain foreign employees working in the United States. These issues are generally beyond the scope of these proposed regulations. Under the existing regulations under section 5000A(f)(1)(E) of the Code, there are procedures for health benefits coverage not otherwise designated under section 5000A(f)(1) of the Code as minimum essential coverage to be recognized by the Secretary of HHS, in coordination with the Secretary of the Treasury, as minimum essential coverage. The Secretary of HHS has provided that coverage under a group health plan

[23] 26 CFR 54.9831–1(b), 29 CFR 2590.732(b), 45 CFR 146.145(b).

[24] See *e.g.,* 26 CFR 1.460–6(d)(4)(i)(D)(*1*).

[25] For this purpose, generally ''minimum value'' takes into account the provision of ''essential health benefits'' as defined in section 1302(b)(1) of the Affordable Care Act.

provided through insurance regulated by a foreign government is minimum essential coverage for expatriates who meet specified conditions.[26] Furthermore, plan sponsors of health coverage that is not recognized as minimum essential coverage through statute, regulation, or guidance may submit an application to CMS for minimum essential coverage recognition pursuant to 45 CFR 156.604.[27] For a complete list of coverage recognized by CMS as minimum essential coverage under section 5000A(f)(1)(E) of the Code, see *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html.*

Comments also requested that policies sold by non-United States health insurance issuers be treated as minimum essential coverage under section 5000A of the Code, or as expatriate health plans. Section 3(d)(5)(A) of the EHCCA specifies that the terms ''health insurance issuer'' and ''health insurance coverage'' have the meanings given those terms by section 2791 of the PHS Act. Section 2791 of the PHS Act (and parallel provisions in section 9832(b) of the Code and section 733(b) of ERISA) define those terms by reference to an entity licensed to engage in the business of insurance in a State and subject to State law that regulates insurance. Under section 2791 of the PHS Act, the term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Consistent with those provisions, these proposed regulations limit an expatriate health insurance issuer to a health insurance issuer within the meaning of those sections (and that meets the other requirements set forth in the proposed regulations). As such, a non-United States health insurance issuer does not qualify as an expatriate health insurance issuer within the meaning of the EHCCA, and coverage issued by a non-United States issuer that is not otherwise minimum essential coverage is not minimum essential coverage pursuant to the EHCCA.

Definition of Expatriate Health Plan Administrator

The proposed regulations define ''expatriate health plan administrator,'' with respect to self-insured coverage, as an administrator of self-insured coverage that generally satisfies the same requirements as an ''expatriate health insurance issuer.''

Definition of Qualified Expatriate

Consistent with section 3(d)(3) of the EHCCA, the proposed regulations define ''qualified expatriate'' as one of three types of individuals. The first type of qualified expatriate, a category A expatriate, is an individual who has the skills, qualifications, job duties, or expertise that has caused the individual's employer to transfer or assign the individual to the United States for a specific and temporary purpose or assignment that is tied to the individual's employment with the employer. A category A expatriate may only be an individual who: (1) The plan sponsor has reasonably determined requires access to health coverage and other related services and support in multiple countries, (2) is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross-border moving expenses, or compensation to enable the individual to return to the individual's home country), and (3) is not a national of the United States. The proposed regulations provide 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 and other related services and support in multiple countries. Furthermore, under the proposed regulations, the offer of a one-time *de minimis* benefit would not meet the standard for the ''periodic'' offer of ''other multinational benefits.''

Section 3(d)(3)(B) of the EHCCA provides that a second type of qualified expatriate, a category B expatriate, is an individual who works outside the United States for a period of at least 180 days in a consecutive 12-month period that overlaps with the plan year. A comment requested that the regulations clarify that the 12-month period could either be within a single plan year, or across two consecutive plan years. Consistent with the statutory language, the proposed regulations provide that a category B expatriate is an individual who is a national of the United States and who works outside the United States for at least 180 days in a consecutive 12-month period that is within a single plan year, or across two consecutive plan years. Section 3(d)(2)(C)(ii) of the EHCCA requires an expatriate health plan provided to category B expatriates to cover certain specified services, such as inpatient and outpatient services, in the country in which the individual is ''present in connection'' with his employment. The Departments request comments on whether it would be helpful to provide further administrative clarification of this statutory language regarding the country or countries in which the services must be provided, and, if so, whether there are facts or circumstances that will present particular challenges in applying this rule.

Finally, consistent with section 3(d)(3)(C) of the EHCCA, the proposed regulations provide that a third type of qualified expatriate, a category C expatriate, is an individual who is a member of a group of similarly situated individuals that is formed for the purpose of traveling or relocating internationally in service of one or more of the purposes listed in section 501(c)(3) or (4) of the Code, or similarly situated organizations or groups, and meets certain other conditions.[28] A category C expatriate does not include an individual in a group that is formed primarily for the sale or purchase of health insurance coverage. To qualify as this type of qualified expatriate, the Secretary of HHS, in consultation with the Secretary of the Treasury and the Secretary of Labor, must determine that the group requires access to health coverage and other related services and support in multiple countries. The proposed regulations clarify that a category C expatriate does not include an individual whose international travel or relocation is related to employment. Thus, an individual whose travel is employment-related may be a qualified expatriate only in category A or B. The proposed regulations also provide 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 (or in the case of a policy year that is less than 12 months, at least

[26] See CMS Insurance Standards Bulletin Series. CCIIO Sub-Regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage (Oct. 31, 2013), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mec-guidance-10-31-2013.pdf.*

[27] See CMS Insurance Standards Bulletin Series. CCIIO Sub-Regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage (Oct. 31, 2013), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mec-guidance-10-31-2013.pdf.* See also CMS Insurance Standards Bulletin Series. CCIIIO Sub-Regulatory Guidance: Minimum Essential Coverage.

[28] Code section 501(c)(3) describes an organization formed for religious, charitable, scientific, public safety, literary, or educational purposes, or to foster national or international amateur sports competition, or for the prevention of cruelty to children or animals, and not for political candidate campaign or legislative purposes or propaganda. Code section 501(c)(4) describes an organization operated exclusively for the promotion of social welfare.

half of the policy year), and 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 regulations provide that a group of category C expatriates must also meet the test for having associational ties under section 2791(d)(3)(B) through (F) of the PHS Act (42 U.S.C. 300gg–91(d)(3)(B) through (F)).

For purposes of section 3(d)(3)(C)(iii) of the EHCCA, the proposed regulations provide that the Secretary of HHS, in consultation with the Secretary of the Treasury and the Secretary of Labor, has determined that, in the case of a group of similarly situated individuals that meets all of the criteria in the proposed regulations, the group requires access to health coverage and other related services and support in multiple countries.

Comments in response to Notice 2015–43 requested that category C expatriates not be limited to individuals expected to travel or reside in the United States for 12 or fewer months. While the EHCCA does not include a time limit for category C expatriates, section 3(e) of the EHCCA provides that the Departments ''may promulgate regulations necessary to carry out this Act, including such rules as may be necessary to prevent inappropriate expansion of the exclusions under the Act from applicable laws and regulations.'' In the group market, the EHCCA and the proposed regulations define a category A expatriate with respect to a ''specific and temporary purpose or assignment'' tied to the individual's employment in the United States. It is the view of HHS, in consultation with the Departments of Labor and the Treasury, that similar safeguards are necessary in the individual market to prevent inappropriate expansion of the exception for category C expatriates.

Comments are requested on all aspects of the proposed definition of a category C expatriate. Comments are also requested on the time limit for category C expatriates being expected to travel or reside in the United States, and what standards, if any, may be adopted in lieu of the 12-month maximum that would ensure that the definition does not permit inappropriate expansion of the exception. For example, comments are requested on whether a ''specific and temporary purpose'' standard should be adopted for category C expatriates, consistent with the standard for category A expatriates, or whether category C expatriates should be expected to seek medical care outside the United States at least one time per year in order to be considered to reasonably require access to health coverage and other related services and support in multiple countries. Comments are also requested on the proposed standard with respect to category C expatriates being 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, and whether there are fact patterns in which the 12-month period could either be within a single policy year, or across two consecutive policy years.

Definitions of Group Health Plan and United States

Consistent with section 3(d)(5)(A) of the EHCCA, for purposes of applying the definition of expatriate health plan, ''group health plan'' means a group health plan as defined under 26 CFR 54.9831–1(a)(1), 29 CFR 2590.732(a)(1) or 45 CFR 146.145(a)(1), as applicable. Consistent with section 3(d)(4) of the EHCCA, the proposed regulations define ''United States'' to mean the 50 States, the District of Columbia and Puerto Rico.

Section 9010 of the ACA

Section 3(c)(1) of the EHCCA provides that, for purposes of the health insurance providers fee imposed by section 9010 of the ACA, a qualified expatriate enrolled in an expatriate health plan is not a United States health risk for calendar years after 2015. Section 3(c)(2) of the EHCCA provides a special rule applicable to calendar years 2014 and 2015. The Treasury Department and the IRS issued Notices 2015–29 and 2016–14 to address the definition of expatriate health plan for purposes of the health insurance providers fee imposed by section 9010 for the 2014, 2015, and 2016 fee years. No fee is due in the 2017 fee year because the Consolidated Appropriations Act suspends collection of the health insurance providers fee imposed by section 9010 of ACA for 2017.

These proposed regulations provide that, for any fee that is due on or after the date final regulations are published in the **Federal Register**, a qualified expatriate enrolled in an expatriate health plan as defined in these proposed regulations is not a United States health risk. These proposed regulations also authorize the IRS to specify in guidance in the Internal Revenue Bulletin the manner of determining excluded premiums for qualified expatriates in expatriate health plans. Until the date the final regulations are published in the **Federal Register**, taxpayers may rely on these proposed regulations with respect to any fee that is due beginning with the 2018 fee year.

Federal Tax Provision: Section 162(m)(6) of the Code

Section 162(m)(6) of the Code, as added by section 9014 of the ACA, in general, limits to $500,000 the allowable deduction for remuneration attributable to services performed by certain individuals for a covered health insurance provider. For taxable years beginning after December 31, 2012, section 162(m)(6)(C)(i) of the Code and 26 CFR 1.162–31(b)(4)(A) provide that a health insurance issuer is a covered health insurance provider if not less than 25 percent of the gross premiums that it receives from providing health insurance coverage during the taxable year are from minimum essential coverage. Section 3(a)(3) of the EHCCA provides that the provisions of the ACA (which include section 162(m)(6) of the Code) do not apply to expatriate health insurance issuers with respect to coverage offered by such issuers under expatriate health plans. Consistent with this rule, the proposed regulations exclude from the definition of the term ''premium'' for purposes of section 162(m)(6) of the Code amounts received in payment for coverage under an expatriate health plan. As a result, those amounts received are included in neither the numerator nor the denominator for purposes of determining whether the 25 percent standard under section 162(m)(6)(C)(i) of the Code and 26 CFR 1.162–31(b)(4)(A) is met, and they have no impact on whether a particular issuer is a covered health insurance provider.

Federal Tax Provision: Section 4980I of the Code

Section 3(b)(2) of the EHCCA provides that section 4980I of the Code applies to employer-sponsored coverage of a qualified expatriate who is assigned, rather than transferred, to work in the United States. As amended by section 101 of Division P of the Consolidated Appropriations Act, section 4980I of the Code first applies to coverage provided in taxable years beginning after December 31, 2019. Comments in response to Notice 2015–43 requested additional guidance on what it means for an employer to assign rather than transfer an employee. These proposed regulations do not address the interaction of the EHCCA and section 4980I of the Code because the Treasury Department and the IRS anticipate that this issue will be addressed in future

guidance promulgated under section 4980I of the Code.

Federal Tax Provision: Section 5000A of the Code and Minimum Essential Coverage

The proposed regulations provide that, beginning January 1, 2017, coverage under an expatriate health plan that provides coverage for a qualified expatriate qualifies as minimum essential coverage for all participants in the plan. If the expatriate health plan provides coverage to category A or category B expatriates, the coverage of any participant in the plan is treated as an eligible employer-sponsored plan under section 5000A(f)(2) of the Code. If the expatriate health plan provides coverage to category C expatriates, the coverage of any enrollee in the plan is treated as a plan in the individual market under section 5000A(f)(1)(C) of the Code.

Federal Tax Provision: Sections 6055 and 6056 of the Code

Section 3(b)(2) of the EHCCA permits the use of electronic media to provide the statements required under sections 6055 and 6056 of the Code to individuals for coverage under an expatriate health plan unless the primary insured has explicitly refused to receive the statement electronically. The proposed regulations provide that, for an expatriate health plan, the recipient is treated as having consented to receive the required statement electronically unless the recipient has explicitly refused to receive the statement in an electronic format. In addition, the proposed regulations provide that the recipient may explicitly refuse either electronically or in a paper document. For a recipient to be treated as having consented under this special rule, the furnisher must provide a notice in compliance with the general disclosure requirements under sections 6055 and 6056 that informs the recipient that the statement will be furnished electronically unless the recipient explicitly refuses to consent to receive the statement in electronic form. The notice must be provided to the recipient at least 30 days prior to the due date for furnishing of the first statement the furnisher intends to furnish electronically to the recipient. Absent receipt of this notice, a recipient will not be treated as having consented to electronic furnishing of statements. Treasury and IRS request comments on further guidance that will assist issuers and plan sponsors in providing this notice in the least burdensome manner while still ensuring that the recipient has sufficient information and opportunity to opt out of the electronic reporting if the recipient desires. For example, Treasury and the IRS specifically request comments on whether the ability to provide this notice as part of the enrollment materials for the coverage would meet these goals.

Federal Tax Provision: PCORTF Fee

The proposed regulations provide that the excise tax under sections 4375 and 4376 of the Code (the PCORTF fee) does not apply to an expatriate health plan as defined at 26 CFR 54.9831–1(f)(3). Section 4375 of the Code limits the application of the fee to policies issued to individuals residing in the United States. Existing regulations under sections 4375, 4376, and 4377 of the Code exclude coverage under a plan from the fee if the plan is designed specifically to cover primarily employees who are working and residing outside the United States. A comment requested clarification about the existing PCORTF fee exemption for plans that primarily cover employees working and residing outside the United States. Consistent with the provisions of the EHCCA, the proposed regulations expand the exclusion from the PCORTF fee to also exclude an expatriate health plan regardless of whether the plan provides coverage for qualified expatriates residing or working in or outside the United States if the plan is an expatriate health plan.

Section 1341 of the ACA: Transitional Reinsurance Program

A comment also requested that the current exclusion under the PCORTF fee regulations for individuals working and residing outside the United States be applied to the transitional reinsurance fee under section 1341 of the ACA. Existing regulations relating to section 1341 of the ACA include an exception for certain expatriate health plans,[29] including expatriate group health coverage as defined by the Secretary of HHS and, for the 2015 and 2016 benefit years, self-insured group health plans with respect to which enrollment is limited to participants who reside outside their home country for at least six months of the plan year, and any covered dependents. HHS solicits comment on whether amendments are needed to 45 CFR 153.400(a)(1)(iii) to clarify the alignment with the EHCCA and exempt all expatriate plans from the requirement to make reinsurance contributions.

[29] 45 CFR 153.400(a)(1)(iii).

Section 2718 of the PHS Act: MLR Program

Section 2718 of the PHS Act, as added by sections 1001 and 10101 of the ACA, generally requires health insurance issuers to provide rebates to consumers if issuers do not achieve specified MLRs, as well as to submit an annual MLR report to HHS. The proposed regulations provide that expatriate policies described in 45 CFR 158.120(d)(4) continue to be subject to the reporting and rebate requirements of 45 CFR part 158, but update the description of expatriate policies in 45 CFR 158.120(d)(4) to exclude policies that are expatriate health plans under the EHCCA. Given this modification, issuers may find that the number of expatriate policies that remain subject to MLR requirements is low, and that it is administratively burdensome and there is no longer a qualitative justification for continuing separate reporting of such policies. Therefore, comments are requested on whether the treatment of expatriate policies for purposes of the MLR regulations should be amended so that expatriate policies that do not meet the definition of expatriate health plan under the EHCCA would not be required to be reported separately from other health insurance policies.

Section 833(c)(5) of the Code, as added by section 9016 of the ACA, and amended by section 102 of Division N of the Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. 113–235, 128 Stat. 2130), provides that section 833(a)(2) and (3) do not apply to any organization unless the organization's MLR for the taxable year was at least 85 percent. In describing the MLR computation under section 833(c)(5), the statute and implementing regulations provide that the elements in the MLR computation are to be ''as reported under section 2718 of the Public Service Health Act.'' Accordingly, the proposed regulations under section 2718 of the PHS Act would effectively apply the EHCCA exemption to section 833(c)(5) of the Code by carving out expatriate health plans under the EHCCA from the section 833(c)(5) requirements as well.

Excepted Benefits

Supplemental Health Insurance Coverage

The proposed regulations incorporate the guidance from the Affordable Care Act Implementation FAQs Part XXIII addressing supplemental health insurance products that provide categories of benefits in addition to those in the primary coverage. Under the proposed regulations, if group or

individual supplemental health insurance coverage provides benefits for items and services not covered by the primary coverage (referred to as providing ''additional categories of benefits''), the coverage would be considered to be designed ''to fill gaps in primary coverage,'' for purposes of being supplemental excepted benefits if none of the benefits provided by the supplemental policy are an EHB, as defined for purposes of section 1302(b) of the ACA, in the State in which the coverage is issued. Conversely, if any benefit provided by the supplemental policy is an EHB in the State where the coverage is issued, the insurance coverage would not be supplemental excepted benefits under the proposed regulations. This standard is proposed to apply only to the extent that the supplemental health insurance provides coverage of additional categories of benefits. Supplemental health insurance products that both fill in cost sharing in the primary coverage, such as coinsurance or deductibles, and cover additional categories of benefits that are not EHB, also would be considered supplemental excepted benefits under these proposed regulations provided all other criteria are met.

Travel Insurance

The Departments are aware that certain travel insurance products may include limited health benefits. However, these products typically are not designed as major medical coverage. Instead, the risks being insured relate primarily to: (1) The interruption or cancellation of a trip (2) the loss of baggage or personal effects; (3) damages to accommodations or rental vehicles; or (4) sickness, accident, disability, or death occurring during travel, with any health benefits usually incidental to other coverage.

Section 2791(c)(1)(H) of the PHS Act, section 733(c)(1)(H) of ERISA, and section 9832(c)(1)(H) of the Code provide that the Departments may, in regulations, designate as excepted benefits ''benefits for medical care that are secondary or incidental to other insurance benefits.'' Pursuant to this authority, and to clarify which types of travel-related insurance products are excepted benefits under the PHS Act, ERISA, and the Code, the proposed regulations provide that certain travel-related products that provide only incidental health benefits are excepted benefits. The proposed regulations define the term ''travel insurance'' as insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed. This definition is consistent with the definition of travel insurance under final regulations for the health insurance providers fee imposed by section 9010 of the ACA issued by the Treasury Department and the IRS,[30] which uses a modified version of the National Association of Insurance Commissioners (NAIC) definition of travel insurance.

Hospital Indemnity and Other Fixed Indemnity Insurance

These proposed regulations also include an amendment to the ''noncoordinated excepted benefits'' category as it relates to hospital indemnity and other fixed indemnity insurance in the group market. Since the issuance of final regulations defining excepted benefits, the Departments have become aware of some hospital indemnity and other fixed indemnity insurance policies that provide comprehensive benefits related to health care costs. In addition, although hospital indemnity and other fixed indemnity insurance under section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code is not intended to be major medical coverage, the Departments are aware that some group health plans that provide coverage through hospital indemnity or other fixed indemnity insurance policies that meet the conditions necessary to be an excepted benefit have made representations to participants that the coverage is minimum essential coverage under section 5000A of the Code. The Departments are concerned that some individuals may incorrectly understand these policies to be comprehensive major medical coverage that would be considered minimum essential coverage.

To avoid confusion among group health plan enrollees and potential enrollees, the proposed regulations revise the conditions necessary for hospital indemnity and other fixed indemnity insurance in the group market to be excepted benefits so that any application or enrollment materials provided to enrollees and potential enrollees at or before the time enrollees and potential enrollees are given the opportunity to enroll in the coverage must include a statement that the coverage is a supplement to, rather than a substitute for, major medical coverage and that a lack of minimum essential coverage may result in an additional tax payment. The proposed regulations include specific language that must be used by group health plans and issuers of group health insurance coverage to satisfy this notice requirement, which is consistent with the notice requirement for individual market fixed indemnity coverage under regulations issued by HHS.[31] The Departments request comments on this proposed notice requirement as well as whether any additional requirements should be added to prevent confusion among enrollees and potential enrollees regarding the limited coverage provided by hospital indemnity and other fixed indemnity insurance. The Departments anticipate that conforming changes will be made in the final regulations to ensure the notice language in the individual market is consistent with the notice language in the group market, and solicit comments on this approach.

Additionally, the Departments have become aware of hospital indemnity or other fixed indemnity insurance policies that provide benefits for doctors' visits at a fixed amount per visit, for prescription drugs at a fixed amount per drug, or for certain services at a fixed amount per day but in amounts that vary by the type of service. These types of policies do not meet the condition that benefits be provided on a per day (or per other time period, such as per week) basis. Accordingly, the proposed regulations clarify this standard by stating that the amount of benefits provided must be determined without regard to the type of items or services received. The proposed regulations add two examples demonstrating that group health plans and issuers of group health insurance coverage that provide coverage through hospital indemnity or fixed indemnity insurance policies that provide benefits based on the type of item or services received do not meet the conditions necessary to be an excepted benefit. The first example would incorporate into regulations guidance previously provided by the Departments in Affordable Care Act Implementation FAQs Part XI, which clarified that if a policy provides benefits in varying amounts based on the type of procedure

[30] 26 CFR 57.2(h)(4).

[31] 45 CFR 148.220(b)(4)(iv).

or item received, the policy does not satisfy the condition that benefits be provided on a per day (or per other time period, such as per week) basis. The second example demonstrates that a hospital indemnity or other fixed indemnity insurance policy that provides benefits for certain services at a fixed amount per day, but in varying amounts depending on the type of service, does not meet the condition that benefits be provided on a per day (or per other time period, such as per week) basis. The Departments request comments on these examples specifically, as well as on the requirement that hospital indemnity and other fixed indemnity insurance in the group market that are excepted benefits must provide benefits on a per day (or per other time period, such as per week) basis in an amount that does not vary based on the type of items or services received. The Departments also request comments on whether the conditions for hospital indemnity or other fixed indemnity insurance to be considered excepted benefits should be more substantively aligned between the group and individual markets. For example, the requirements for hospital indemnity or other fixed indemnity insurance in the individual market could be modified to be consistent with the group market provisions of these proposed regulations by limiting payment strictly on a per-period basis and not on a per-service basis.

Specified Disease Coverage

The Departments have been asked whether a policy covering multiple specified diseases or illnesses may be considered to be excepted benefits. The statute provides that the noncoordinated excepted benefits category includes ''coverage of a specified disease or illness'' if the coverage meets the conditions for being offered as independent, noncoordinated benefits, and the Departments' implementing regulations identify cancer-only policies as one example of specified disease coverage.[32] The Departments are concerned that individuals who purchase a specified disease policy covering multiple diseases or illnesses (including policies that cover one overarching medical condition such as ''mental illness'' as opposed to a specific condition such as depression) may incorrectly believe they are purchasing comprehensive medical coverage when, in fact, these polices may not include many of the important consumer protections under the PHS Act, ERISA, and the Code. The Departments solicit comments on this issue and on whether, if such policies are permitted to be considered excepted benefits, protections are needed to ensure such policies are not mistaken for comprehensive medical coverage. For example, the Departments solicit comments on whether to limit the number of diseases or illnesses that may be covered in a specified disease policy that is considered to be excepted benefits or whether issuers should be required to disclose that such policies are not minimum essential coverage under section 5000A(f) of the Code.

Short-Term, Limited-Duration Insurance

Under existing regulations, short-term, limited-duration insurance means ''health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.'' [33] Before enactment of the ACA, short-term, limited-duration insurance was an important means for individuals to obtain health coverage when transitioning from one job to another (and from one group health plan to another) or in a similar situation. But with the guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the ACA, short-term, limited-duration insurance is no longer the only means to obtain transitional coverage.

The Departments recently have become aware that short-term, limited-duration insurance is being sold to address situations other than the situations that the exception was initially intended to address.[34] In some instances individuals are purchasing this coverage as their primary form of health coverage and, contrary to the intent of the 12-month coverage limitation in the current definition of short-term, limited-duration insurance, some issuers are providing renewals of the coverage that extend the duration beyond 12 months. The Departments are concerned that these policies, because they are exempt from market reforms, may have significant limitations, such as lifetime and annual dollar limits on EHBs and pre-existing condition exclusions, and therefore may not provide meaningful health coverage. Further, because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for ACA-compliant coverage.

To address the issue of short-term, limited-duration insurance being sold as a type of primary coverage, the proposed regulations revise the definition of short-term, limited-duration insurance so that the coverage must be less than three months in duration, including any period for which the policyholder renews or has an option to renew with or without the issuer's consent. The proposed regulations also provide that a notice must be prominently displayed in the contract and in any application materials provided in connection with enrollment in such coverage with the following language: 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.

This change would align the definition more closely with the initial intent of the regulation: To refer to coverage intended to fill temporary coverage gaps when an individual transitions between primary coverage. Further, limiting the coverage to less than three months improves coordination with the exemption from the individual shared responsibility provision of section 5000A of the Code for gaps in coverage of less than three months (the short coverage gap exemption), 26 CFR 1.5000A–3. Under current law, individuals who are enrolled in short-term, limited-duration coverage instead of minimum essential coverage for three months or more are generally not eligible for the short coverage gap exemption. The proposed regulations help ensure that individuals who purchase short-term, limited-duration coverage will still be eligible for the short coverage gap exemption (assuming other requirements are met) during the temporary coverage period.

In addition to proposing to reduce the length of short-term, limited-duration insurance to less than three months, the proposed regulations add the words ''with or'' in front of ''without the issuer's consent'' to address the Departments' concern that some issuers are taking liberty with the current

[32] 26 CFR 54.9831–1(c)(4), 29 CFR 2590.732(c)(4), 45 CFR 146.145(b)(4) and 148.220(b)(3).

[33] 26 CFR 54.9801–2, 29 CFR 2590.702–2, 45 CFR 144.103.

[34] See *e.g.,* Mathews, Anna W. ''Sales of Short-Term Health Policies Surge,'' *The Wall Street Journal* April 10, 2016, available at *http://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539.*

definition of short-term, limited-duration insurance either by automatically renewing such policies or having a simplified reapplication process with the result being that such coverage lasts much longer than 12 months and serves as an individual's primary coverage but does not contain the important protections of the ACA. As indicated above, this type of coverage should only be sold for the purpose of providing coverage on a short-term basis such as filling in coverage gaps as a result of transitioning from one group health plan to another. The addition of the words ''with or'' clarifies that short-term, limited-duration insurance must be less than 3 months in total taking into account any option to renew or to reapply for the same or similar coverage.

The Departments seek comment on this proposal, including information and data on the number of short-term, limited-duration insurance policies offered for sale in the market, the types of individuals who typically purchase this coverage, and the reasons for which they purchase it.

Definition of EHB for Purposes of the Prohibition on Lifetime and Annual Limits

On November 18, 2015, the Departments issued final regulations implementing section 2711 of the PHS Act.[35] The final regulations provide that, for plan years beginning on or after January 1, 2017, a plan or issuer that is not required to provide EHBs must define EHB, for purposes of the prohibition on lifetime and annual dollar limits, in a manner consistent with any of the 51 EHB base-benchmark plans applicable in a State or the District of Columbia, or one of the three FEHBP base-benchmarks, as specified under 45 CFR 156.100.

The final regulations under section 2711 of the PHS Act include a reference to selecting a ''base-benchmark'' plan, as specified under 45 CFR 156.100, for purposes of determining which benefits cannot be subject to lifetime or annual dollar limits. The base-benchmark plan selected by a State or applied by default under 45 CFR 156.100, however, may not reflect the complete definition of EHB in the applicable State. For that reason, the Departments propose to amend the regulations at 26 CFR 54.9815–2711(c), 29 CFR 2590.715–2711(c), and 45 CFR 147.126(c) to refer to the provisions that capture the complete definition of EHB in a State. Specifically, the Departments propose to replace the phrase ''in a manner consistent with one of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3) or one of the base-benchmark plans selected by a State or applied by default pursuant to 45 CFR 156.100'' in each of the regulations with the following: ''In a manner that is consistent with (1) one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or (2) one of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.'' This change reflects the possibility that base-benchmark plans, including the FEHBP plan options, could require supplementation under 45 CFR 156.110, and ensures the inclusion of State-required benefit mandates enacted on or before December 31, 2011 in accordance with 45 CFR 155.170, which when coupled with a State's EHB-benchmark plan, establish the definition of EHB in that State under regulations implementing section 1302(b) of the ACA.[36] The Departments seek comment on the requirement that, when one of the FEHBP plan options is selected as the benchmark, it would be supplemented, as needed, to ensure coverage in all ten statutory EHB categories, and the benchmark plan options that should be available for this purpose.

Proposed Applicability Date and Reliance

Except as otherwise provided herein, these proposed regulations are proposed to be applicable for plan years (or, in the individual market, policy years) beginning on or after January 1, 2017. Issuers, employers, administrators, and individuals are permitted to rely on these proposed regulations pending the applicability date of final regulations in the **Federal Register**. To the extent final regulations or other guidance is more restrictive on issuers, employers, administrators, and individuals than these proposed regulations, the final regulations or other guidance will be applied without retroactive effect and issuers, employers, administrators, and individuals will be provided sufficient time to come into compliance with the final regulations.

III. Economic Impact and Paperwork Burden

A. Summary—Department of Labor and Department of Health and Human Services

As stated above, the proposed regulations would provide guidance on the rules for expatriate health plans, expatriate health plan issuers, and qualified expatriates under the EHCCA. The EHCCA generally provides that the requirements of the ACA do not apply with respect to expatriate health plans, expatriate health insurance issuers for coverage under expatriate health plans, and employers in their capacity as plan sponsors of expatriate health plans.

The proposed regulations address how certain requirements relating to minimum essential coverage under section 5000A of the Code, the health care reporting provisions of sections 6055 and 6056 of the Code, and the health insurance providers fee imposed by section 9010 of the ACA continue to apply subject to certain provisions while providing that the excise tax under sections 4375 and 4376 of the Code do not apply to expatriate health plans.

The proposed regulations also propose amendments to the Departments' regulations concerning excepted benefits, which would specify the conditions for supplemental health insurance products that are designed ''to fill gaps in primary coverage'' by providing additional categories of benefits (as opposed to filling in gaps in cost sharing) to constitute supplemental excepted benefits, and clarify that certain travel-related insurance products that provide only incidental health benefits constitute excepted benefits. The proposed regulations also require that, to be considered hospital indemnity or other fixed indemnity insurance in the group market, any application or enrollment materials provided to participants at or before the time participants are given the opportunity to enroll in the coverage must include a statement that the coverage is a supplement to, rather than a substitute for, major medical coverage and that a lack of minimum essential

[35] 80 FR 72192.

[36] In the HHS Notice of Benefit and Payment Parameters for 2016 published February 27, 2015 (80 FR 10750), HHS instructed States to select a new base-benchmark plan to take effect beginning with plan or policy years beginning in 2017. The new final EHB base-benchmark plans selected as a result of this process are publicly available at *downloads.cms.gov/cciio/Final%20List%20of%20BMPs_15_10_21.pdf.* Additional information about the new base-benchmark plans, including plan documents and summaries of benefits, is available at *www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.* The definition of EHB in each of the 50 states and the District of Columbia is based on the base-benchmark plan, and takes into account any additions to the base-benchmark plan, such as supplementation under 45 CFR 156.110, and State-required benefit mandates in accordance with 45 CFR 155.170.

coverage may result in an additional tax payment. Further, the regulations clarify that hospital indemnity and other fixed indemnity insurance must pay a fixed dollar amount per day (or per other time period, such as per week) regardless of the type of items or services received.

The regulations also propose revisions to the definition of short-term, limited-duration insurance so that the coverage has to be less than 3 months in duration (as opposed to the current definition of less than 12 months in duration), and that a notice must be prominently displayed in the contract and in any application materials provided in connection with the coverage that provides that such coverage is not minimum essential coverage.

The proposed regulations also include amendments to 45 CFR part 158 to clarify that the MLR reporting requirements do not apply to expatriate health plans under the EHCCA.

Finally, the proposed regulations propose to amend the definition of ''essential health benefits'' for purposes of the prohibition of annual and lifetime dollar limits for group health plans and health insurance issuers that are not required to provide essential health benefits.

The Departments are publishing these proposed regulations to implement the protections intended by the Congress in the most economically efficient manner possible. The Departments have examined the effects of this rule as required by Executive Order 13563 (76 FR 3821, January 21, 2011), Executive Order 12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

B. Executive Orders 12866 and 13563—Department of Labor and Department of Health and Human Services

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a final rule—(1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (for example, $100 million or more in any 1 year), and a ''significant'' regulatory action is subject to review by the OMB. The Departments have determined that this regulatory action is not likely to have economic impacts of $100 million or more in any one year, and therefore is not significant within the meaning of Executive Order 12866. The Departments expect the impact of these proposed regulations to be limited because they do not require any additional action or impose any requirements on issuers, employers and plan sponsors.

1. Need for Regulatory Action

Consistent with the EHCCA, enacted as Division M of the Consolidated Clarification Continuing Appropriations Act, 2015 Public Law 113–235 (128 Stat. 2130), these proposed regulations provide that the market reform provisions enacted as part of the ACA generally do not apply to expatriate health plans, any employer solely in its capacity as a plan sponsor of an expatriate health plan, and any expatriate health insurance issuer with respect to coverage under an expatriate health plan. Further, the proposed regulations define the benefit and administrative requirements for expatriate health issuers, expatriate health plans, and qualified expatriates and provide clarification regarding the applicability of certain fee and reporting requirements under the Code.

Consistent with section 2 of the EHCCA, these proposed regulations are necessary to carry out the intent of Congress that (1) American expatriate health insurance issuers should be permitted to compete on a level playing field in the global marketplace; (2) the global competitiveness of American companies should be encouraged; and (3) in implementing the health insurance providers fee imposed by section 9010 of the ACA and other provisions of the ACA, the unique and multinational features of expatriate health plans and the United States companies that operate such plans and the competitive pressures of such plans and companies should continue to be recognized.

In response to feedback the Departments have received from stakeholders, the proposed regulations would also clarify the conditions for supplemental health insurance and travel insurance to be considered excepted benefits. These clarifications will provide health insurance issuers offering supplemental insurance coverage and travel insurance products with a clearer understanding of whether these types of coverage are subject to the market reforms under title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code. The proposed regulations also would amend the definition of short-term, limited-duration insurance and impose a new notice requirement in response to recent reports that this type of coverage is being sold for purposes other than for which the exclusion for short-term, limited-duration insurance was initially intended to cover.

2. Summary of Impacts

These proposed regulations would implement the rules for expatriate health plans, expatriate health insurance issuers, and qualified expatriates under the EHCCA. The proposed regulations also outline the conditions for travel insurance and supplemental insurance coverage to be considered excepted benefits, and revise the definition of short-term, limited-duration insurance.

Based on the NAIC 2014 Supplemental Health Care Exhibit Report,[37] which generally uses the definition of expatriate coverage in the MLR final rule at 45 CFR 158.120(d)(4),[38] there are an estimated

[37] NAIC, 2014 Supplemental Health Care Exhibit Report, Volume 1 (2015), available at *http://www.naic.org/documents/prod_serv_statistical_hcs_zb.pdf.*

[38] Section 45 CFR 158.120(d)(4) defines expatriate policies as predominantly group health insurance policies that provide coverage to employees, substantially all of whom are: (1) Working outside their country of citizenship; (2) working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in their home country.

eight issuers (one issuer in the small group market and seven issuers in the large group market) domiciled in the United States that provide expatriate health plans for approximately 270,349 enrollees. While the Departments acknowledge that some expatriate health insurance issuers and employers in their capacity as plan sponsor of an expatriate health plan may incur costs in order to comply with certain provisions of the EHCCA and these proposed regulations, as discussed below, the Departments believe that these costs will be relatively insignificant and limited.

The vast majority of expatriate health plans described in the EHCCA would qualify as expatriate health plans under the transitional relief provided in the Departments' Affordable Care Act Implementation FAQs Part XVIII, Q&A–6 and Q&A–7. The FAQs provide that expatriate health plans with plan years ending on or before December 31, 2016 are exempt from the ACA market reforms and provide that coverage provided under an expatriate group health plan is a form of minimum essential coverage under section 5000A of the Code. The EHCCA permanently exempts expatriate health plans with plan or policy years beginning on or after July 1, 2015 from the ACA market reform requirements and provides that coverage provided under an expatriate health plan is a form of minimum essential coverage under section 5000A of the Code.

Because the Departments believe that most, if not all, expatriate health plans described in the EHCCA would qualify as expatriate health plans under the Departments' previous guidance, and the proposed regulations codify the provisions of the EHCCA by making the temporary relief in the Departments' Affordable Care Act Implementation FAQs Part XVIII, Q&A–6 and Q&A–7 permanent for specified expatriate health plans, the Departments believe that the proposed regulations will result in only marginal, if any, impact on these plans. Furthermore, the Departments believe the proposed regulations outlining the conditions for travel insurance and supplemental insurance coverage to be considered excepted benefits are consistent with prevailing industry practice and will not result in significant cost to health insurance issuers of these products.

The Departments believe that any costs incurred by issuers of short-term, limited-duration insurance and hospital indemnity and other fixed indemnity insurance to include the required notice in application or enrollment materials will be negligible since the Departments have provided the exact text for the notice. Further, the Departments note that issuers of hospital indemnity and other fixed indemnity insurance in the individual market already provide a similar notice.

As a result, the Departments have concluded that the impacts of these proposed regulations are not economically significant. The Departments request comments on the assumptions used to evaluate the economic impact of these proposed regulations, including specific data and information on the number of expatriate health plans.

C. Paperwork Reduction Act

1. Department of the Treasury

The collection of information in these proposed regulations are in 26 CFR 1.6055–2(a)(8) and 301.6056–2(a)(8). The collection of information in these proposed regulations relates to statements required to be furnished to a responsible individual under section 6055 of the Code and statements required to be furnished to an employee under section 6056 of the Code. The collection of information in these proposed regulations would, in accordance with the EHCCA, permit a furnisher to furnish the required statements electronically unless the recipient has explicitly refused to consent to receive the statement in an electronic format. The collection of information contained in this notice of proposed rulemaking will be taken into account and submitted to the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) in connection with the next review of the collection of information for IRS Form 1095–B (OMB # 1545–2252) and IRS Form 1095–C (OMB # 1545–2251).

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by August 9, 2016. Comments are sought on whether the proposed collection of information is necessary for the proper performance of the IRS, including whether the information will have practical utility; the accuracy of the estimated burden associated with the proposed collection of information; how the quality, utility, and clarity of the information to be collected may be enhanced; how the burden of complying with the proposed collection of information may be minimized, including through the application of automated collection techniques and other forms of information technology; and estimates of capital or start-up costs and costs of operation, maintenance, and purchase of service to provide information. Comments on the collection of information should be received by August 9, 2016.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

2. Department of the Treasury, Department of Labor, and Department of Health and Human Services

The proposed regulations provide that to be considered hospital or other fixed indemnity excepted benefits in the group market for plan years beginning on or after January 1, 2017, a notice must be included in any application or enrollment materials provided to participants at or before the time participants are given the opportunity to enroll in the coverage, indicating that the coverage is a supplement to, rather than a substitute for major medical coverage and that a lack of minimum essential coverage may result in an additional tax payment. The proposed regulations also provide that to be considered short-term, limited-duration insurance for policy years beginning on or after January 1, 2017, a notice must be prominently displayed in the contract and in any application materials, stating that the coverage is not minimum essential coverage and that failure to have minimum essential coverage may result in an additional tax payment. The Departments have provided the exact text for these notice requirements and the language will not need to be customized. The burden associated with these notices is not subject to the Paperwork Reduction Act of 1995 in accordance with 5 CFR 1320.3(c)(2) because they do not contain a ''collection of information'' as defined in 44 U.S.C. 3502(11).

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes

certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA) (13 CFR 121.201); (2) a nonprofit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of ''small entity.'') The Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

These proposed regulations are not likely to impose additional costs on small entities. According to SBA size standards, entities with average annual receipts of $38.5 million or less would be considered small entities for these North American Industry Classification System codes. The Departments believe that, since 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. Therefore, the Departments certify that the proposed regulations will not have a significant impact on a substantial number of small entities. In addition, section 1102(b) of the Social Security Act requires agencies to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. These proposed regulations would not affect small rural hospitals. Therefore, the Departments have determined that these proposed regulations would not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Special Analysis—Department of the Treasury

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. Chapter 5) does not apply to these regulations. For applicability of RFA, see paragraph D of this section III.

Pursuant to section 7805(f) of the Code, these regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

F. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 *et seq.*), as well as Executive Order 12875, these proposed rules do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of $146 million adjusted for inflation since 1995.

G. Federalism—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have ''substantial direct effects'' on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the final regulation.

In the Departments' view, these proposed regulations do not have federalism implications, because they do not have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government.

H. Congressional Review Act

These proposed regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*), and, if finalized, will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

I. Statement of Availability of IRS Documents

IRS Revenue Procedures, Revenue Rulings notices, and other guidance cited in this document are published in the Internal Revenue Bulletin (or Cumulative Bulletin) and are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, or by visiting the IRS Web site at *http://www.irs.gov*.

IV. Statutory Authority

The Department of the Treasury regulations are proposed to be adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are proposed pursuant to the authority contained in 29 U.S.C. 1135,and 1191c; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are proposed to be adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 1

Income taxes.

26 CFR Part 46

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

26 CFR Part 54

Pension and excise taxes.

26 CFR Part 57

Health insurance providers fee.

26 CFR Part 301

Procedure and administration.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Parts 144, 146 and 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 148

Administrative practice and procedure, Health care, Health

insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 158

Health insurance, Medical loss ratio, Reporting and rebate requirements.

John Dalrymple,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this 1st day of June 2016.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: June 2, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: June 3, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Amendments to the Regulations

Accordingly, 26 CFR parts 1, 46, 54, 57, and 301 are proposed to be amended as follows:

PART 1—INCOME TAXES

■ 1. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805.* * *

■ 2. Section 1.162–31 is amended by adding paragraph (b)(5)(v) to read as follows:

§ 1.162–31 The $500,000 deduction limitation for remuneration provided by certain health insurance providers.

* * * * *

(b) * * *

(5) * * *

(v) *Expatriate health plan coverage.* For purposes of this section, amounts received in payment for expatriate health plan coverage, as defined in § 54.9831–1(f)(3), are not premiums.

* * * * *

■ 3. Section 1.5000A–2 is amended by adding paragraphs (c)(1)(i)(D) and (d)(3) to read as follows:

§ 1.5000A–2 Minimum essential coverage.

* * * * *

(c) * * *

(1) * * *

(i) * * *

(D) A group health plan that is an expatriate health plan within the meaning of § 54.9831–1(f)(3) of this chapter if the requirements of § 54.9831–1(f)(3)(i) of this chapter are met by providing coverage for qualified expatriates described in § 54.9831–1(f)(6)(i) or (ii) of this chapter.

* * * * *

(d) * * *

(3) *Certain expatriate health plans.* An expatriate health plan within the meaning of § 54.9831–1(f)(3) of this chapter that is not an eligible employer-sponsored plan under paragraph (c)(1)(i)(D) of this section is a plan in the individual market.

* * * * *

■ 4. Section 1.6055–2 is amended by adding paragraph (a)(8) to read as follows:

§ 1.6055–2 Electronic furnishing of statements.

(a) * * *

(8) *Special rule for expatriate health plan coverage*—(i) *In general.* In the case of an individual covered under an expatriate health plan (within the meaning of § 54.9831–1(f)(3) of this chapter), the recipient is treated as having consented under paragraph (a)(2) of this section unless the recipient has explicitly refused to consent to receive the statement in an electronic format. The refusal to consent may be made electronically or in a paper document. A recipient's request for a paper statement is treated as an explicit refusal to receive the statement in electronic format. A furnisher relying on this paragraph (a)(8) must satisfy the requirements of paragraphs (a)(3) through (7) of this section, except that the statement required under paragraph (a)(3) must be provided at least 30 days prior to the time for furnishing under § 1.6055–1(g)(4)(i)(A) of this chapter of the first statement that the furnisher intends to furnish electronically to the recipient, and the other requirements of paragraph (a)(3) are modified to reflect that the statement will be furnished electronically unless the recipient explicitly refuses to consent to receive the statement in an electronic format.

(ii) *Manner and time of notifying recipient.* The IRS may specify in other guidance published in the Internal Revenue Bulletin the manner and timing for the initial notification of recipients that the statement required under paragraph (a)(3) of this section will be furnished electronically unless the recipient explicitly refuses to consent to receive the statement in an electronic format. See § 601.601(d)(2)(ii)(B) of this chapter.

(iii) *Effective/applicability date.* The provisions of this paragraph (a)(8) apply as of January 1, 2017.

* * * * *

PART 46—EXCISE TAXES, HEALTH CARE, HEALTH INSURANCE, PENSIONS, REPORTING AND RECORDKEEPING

■ 5. The authority citation for part 46 continues to read as follows:

Authority: 26 U.S.C. 7805.

■ 6. Section 46.4377–1 is amended by redesignating paragraph (c) as paragraph (d) and adding new paragraph (c) to read as follows:

§ 46.4377–1. Definitions and special rules.

* * * * *

(c) *Treatment of expatriate health plans.* For policy years and plan years that end after January 1, 2017, the fees imposed by sections 4375 and 4376 do not apply to an expatriate health plan within the meaning of § 54.9831–1(f)(3).

* * * * *

PART 54—PENSION AND EXCISE TAXES

■ 7. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805* * *

■ 8. Section 54.9801–2 is amended by:

■ a. Adding in alphabetical order definitions for ''expatriate health insurance issuer'', ''expatriate health plan'', and ''qualified expatriate;''

■ b. Revising the definition of ''short-term, limited-duration insurance''; and

■ c. Adding in alphabetical order a definition for ''travel insurance''.

The additions and revisions read as follows:

§ 54.9801–2 Definitions.

* * * * *

Expatriate health insurance issuer means an expatriate health insurance issuer within the meaning of § 54.9831–1(f)(2).

Expatriate health plan means an expatriate health plan within the meaning of § 54.9831–1(f)(3).

* * * * *

Qualified expatriate means a qualified expatriate within the meaning of § 54.9831–1(f)(6).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract; and

(2) Displays prominently in the contract and in any application materials provided in connection with

enrollment in such coverage in at least 14 point type the following: ''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.''

* * * * *

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

* * * * *

■ 9. Section 54.9815–2711 is amended by revising paragraph (c) to read as follows:

§ 54.9815–2711 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with—

(1) One of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

* * * * *

§ 54.9831–1 [Amended]

■ 10. Section 54.9831–1 is amended in paragraph (b)(1) by removing the reference ''54.9812–1T'' and adding in its place the reference ''54.9812–1, 54.9815–1251 through 54.9815–2719A,'' and in paragraph (c)(1) by removing the reference ''54.9811–1T, 54.9812–1T'' with the phrase ''54.9811–1, 54.9812–1, 54.9815–1251 through 54.9815–2719A''.

■ 11. Section 54.9831–1 is amended:

■ a. In paragraph (c)(2)(vii) by removing ''and'' at the end;

■ b. In paragraph (c)(2)(viii) by adding ''and'' at the end;

■ c. Adding paragraph (c)(2)(ix);

■ d. Revising paragraph (c)(4)(i);

■ e. Adding paragraph (c)(4)(ii)(D);

■ f. Revising paragraphs (c)(4)(iii) and (c)(5)(i)(C); and

■ g. Adding paragraph (f).

The revisions and additions read as follows:

§ 54.9831–1 Special rules relating to group health plans.

* * * * *

(c) * * *

(2) * * *

(ix) Travel insurance within the meaning of § 54.9801–2 of this section.

* * * * *

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if the coverage meets each of the conditions specified in paragraph (c)(4)(ii) of this section.

(ii) * * *

(D) To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other time period, such as per week) of hospitalization or illness (for example, $100/day) without regard to the amount of expenses incurred or the type of items or services received and—

(*1*) The plan or issuer must provide, in any application or enrollment materials provided to participants at or before the time participants are given the opportunity to enroll in the coverage, a notice that prominently displays in at least 14 point type the following language: ''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.''

(*2*) If participants are required to reenroll (in either paper or electronic form) for renewal or reissuance, the notice described in paragraph (c)(4)(ii)(D)(*1*) of this section must be displayed in the reenrollment materials that are provided to the participants at or before the time participants are given the opportunity to reenroll in the coverage.

(*3*) If a notice satisfying the requirements of this paragraph (c)(4)(ii)(D) is timely provided to a participant, the obligation to provide the notice is satisfied for both the plan and the issuer.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example 1,* because the policy pays a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits for doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and prescription drugs at $15 per prescription.

(ii) *Conclusion.* In this *Example 2,* for doctors' visits, surgery, and prescription drugs, payment is not made on a per-period basis, but instead is based on whether a procedure or item is provided, such as whether an individual has surgery or a doctor visit or is prescribed a drug, and the amount of payment varies based on the type of procedure or item. Because benefits related to office visits, surgery, and prescription drugs are not paid based on a fixed dollar amount per day (or per other time period, such as per week), as required under paragraph (c)(4) of this section, the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (c)(4).

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits for certain services at a fixed dollar amount per day, but the dollar amount varies by the type of service.

(ii) *Conclusion.* In this *Example 3,* because the policy provides benefits in a different amount per day depending on the type of service, rather than one specific dollar amount per day regardless of the type of service, the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (c)(4).

(5) * * *

(i) * * *

(C) *Similar supplemental coverage provided to coverage under a group health plan.* To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in the primary coverage. The preceding sentence is satisfied if the coverage is designed to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits in the State where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

* * * * *

(f) *Expatriate health plans and expatriate health insurance issuers*—(1) *In general.* With respect to coverage under an expatriate health plan, the requirements of section 9815 of the Code and implementing rules and regulations (incorporating sections 2701 through 2728 of the Public Health Service Act) do not apply to—

(i) An expatriate health plan (as defined in paragraph (f)(3) of this section),

(ii) An employer, solely in its capacity as plan sponsor of an expatriate health plan, and

(iii) An expatriate health insurance issuer (as defined in paragraph (f)(2) of this section) with respect to coverage under an expatriate health plan.

(2) *Definition of expatriate health insurance issuer*—(i) *In general.* Expatriate health insurance issuer means a health insurance issuer, within the meaning of § 54.9801–2, that issues expatriate health plans and that in the course of its normal business operations—

(A) Maintains network provider agreements that provide for direct claims payments, with health care providers in eight or more countries;

(B) Maintains call centers in three or more countries, and accepts calls from customers in eight or more languages;

(C) Processed at least $1 million in claims in foreign currency equivalents during the preceding calendar year, determined using the Treasury Department's currency exchange rate in effect on the last day of the preceding calendar year;

(D) Makes global evacuation/repatriation coverage available;

(E) Maintains legal and compliance resources in three or more countries; and

(F) Has licenses or other authority to sell insurance in more than two countries, including in the United States.

(ii) *Additional rules.* For purposes of meeting the requirements of this paragraph (f)(2), two or more entities, including one entity that is the expatriate health insurance issuer, that are members of the expatriate health insurance issuer's controlled group (as determined under § 57.2(c) of this chapter) are treated as one expatriate health insurance issuer. Alternatively, the requirements of this paragraph (f)(2) may be satisfied through contracts between an expatriate health insurance issuer and third parties.

(3) *Definition of expatriate health plan.* Expatriate health plan means a plan that satisfies the requirements of paragraphs (f)(3)(i) through (iii) of this section.

(i) *Substantially all qualified expatriates requirement.* Substantially all primary enrollees in the expatriate health plan must be qualified expatriates. For purposes of this paragraph (f)(3)(i), the primary enrollee is the individual covered by the plan or policy whose eligibility for coverage is not due to that individual's status as the spouse, dependent, or other beneficiary of another covered individual. Notwithstanding the foregoing, an individual is not a primary enrollee if the individual is not a national of the United States and the individual resides in his or her country of citizenship. A plan satisfies the requirement of this paragraph (f)(3)(i) for a plan or policy year only if, on the first day of the plan or policy year, less than 5 percent of the primary enrollees (or less than 5 primary enrollees if greater) are not qualified expatriates.

(ii) *Substantially all benefits not excepted benefits requirement.* Substantially all of the benefits provided under the plan or coverage must be benefits that are not excepted benefits described in § 54.9831–1(c).

(iii) *Additional requirements.* To qualify as an expatriate health plan, the plan or coverage must also meet the following requirements:

(A) The plan or coverage provides coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services (comparable to emergency services coverage that was described in and offered under section 8903(1) of title 5, United States Code for plan year 2009) in the following locations—

(*1*) In the case of individuals described in paragraph (f)(6)(i) of this section, in the United States and in the country or countries from which the individual was transferred or assigned, and such other country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate;

(*2*) In the case of individuals described in paragraph (f)(6)(ii) of this section, in the country or countries in which the individual is present in connection with his employment, and such other country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate; or

(*3*) In the case of individuals described in paragraph (f)(6)(iii) of this section, in the country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate.

(B) The plan sponsor reasonably believes that benefits provided by the plan or coverage satisfy the minimum value requirements of section 36B(c)(2)(C)(ii). For this purpose, a plan sponsor is permitted to rely on the reasonable representations of the issuer or administrator regarding whether benefits offered by the issuer or group health plan satisfy the minimum value requirements unless the plan sponsor knows or has reason to know that the benefits fail to satisfy the minimum value requirements.

(C) In the case of a plan or coverage that provides dependent coverage of children, such coverage must be available until an individual attains age 26, unless an individual is the child of a child receiving dependent coverage.

(D) The plan or coverage is:

(*1*) In the case of individuals described in paragraph (f)(6)(i) or (ii) of this section, a group health plan (including health insurance coverage offered in connection with a group health plan), issued by an expatriate health insurance issuer or administered by an expatriate health plan administrator. A group health plan will not fail to be an expatriate health plan merely because any portion of the coverage is provided through a self-insured arrangement.

(*2*) In the case of individuals described in paragraph (f)(6)(iii) of this section, health insurance coverage issued by an expatriate health insurance issuer.

(E) The plan or coverage offers reimbursements for items or services in

local currency in eight or more countries.

(F) The plan or coverage satisfies the provisions of Chapter 100 and regulations thereunder as in effect on March 22, 2010. For this purpose, the plan or coverage is not required to comply with section 9801(e) (relating to certification of creditable coverage) and underlying regulations. However, to the extent the plan or coverage imposes a preexisting condition exclusion, the plan or coverage must ensure that individuals with prior creditable coverage who enroll in the plan or coverage have an opportunity to demonstrate that they have creditable coverage offsetting the preexisting condition exclusion.

(iv) *Example.* The rule of paragraph (f)(3)(i) of this section is illustrated by the following example:

Example. (i) *Facts.* Business has health plan X for 250 U.S. citizens working outside of the United States in Country Y. All of the U.S. citizens working in Country Y satisfy the requirements to be qualified expatriates under § 54.9831–1(f)(6)(ii). In addition to the 250 U.S. citizens, Business employs 100 citizens of Country Y who reside in Country Y and do not satisfy the requirements to be qualified expatriates under § 54.9831–1(f)(6)(ii). Health plan X covers both the U.S. citizens and citizens of Country Y.

(ii) *Conclusion.* Health plan X satisfies the requirement of § 54.9831–1(f)(3)(i) that substantially all primary enrollees of an expatriate health plan be qualified expatriates because 100 percent of the primary enrollees are qualified expatriates. The 100 citizens of Country Y who reside in Country Y are not treated as primary enrollees for purposes of the substantially all requirement of § 54.9831–1(f)(3)(i) because they are not nationals of the United States and they reside in the country of their citizenship.

(4) *Definition of expatriate health plan administrator*—(i) *In general.* Expatriate health plan administrator means an administrator that in the course of its regular business operations—

(A) Maintains network provider agreements that provide for direct claims payments, with health care providers in eight or more countries,

(B) Maintains call centers, in three or more countries, and accepts calls from customers in eight or more languages,

(C) Processed at least $1 million in claims in foreign currency equivalents during the preceding calendar year, determined using the Treasury Department's currency exchange rate in effect on the last day of the preceding calendar year,

(D) Makes global evacuation/repatriation coverage available,

(E) Maintains legal and compliance resources in three or more countries, and

(F) Has licenses or other authority to sell insurance in more than two countries, including in the United States.

(ii) *Additional rules.* For purposes of meeting the requirements of this paragraph (f)(4), two or more entities, including one entity that is the expatriate health plan administrator, that are members of the expatriate health plan administrator's controlled group (as determined under § 57.2(c) of this chapter) are treated as one expatriate health plan administrator. Alternatively, the requirements of this paragraph (f)(4) may be satisfied through contracts between an expatriate health plan administrator and third parties.

(5) *Definition of group health plan.* Group health plan, for purposes of this section, means a group health plan as defined in § 54.9831–1(a).

(6) *Definition of qualified expatriate.* Qualified expatriate, for purposes of this section, means an individual who is described in paragraph (f)(6)(i), (ii), or (iii) of this section.

(i) *Individuals transferred or assigned by their employer to work in the United States.* An individual is described in this paragraph (f)(6)(i) only if such individual has the skills, qualifications, job duties, or expertise that has caused the individual's employer to transfer or assign the individual to the United States for a specific and temporary purpose or assignment that is tied to the individual's employment with such employer. This paragraph (f)(6)(i) applies only to an individual who the plan sponsor has reasonably determined requires access to health coverage and other related services and support in multiple countries, and is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross-border moving expenses, or compensation to enable the individual to return to the individual's home country), and does not apply to any individual who is a national of the United States. For purposes of this paragraph (f)(6)(i), 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 and other related services and support in multiple countries. Furthermore, the offer of a one-time *de minimis* benefit would not meet the standard for the offer of other multinational benefits on a periodic basis.

(ii) *Individuals working outside the United States.* An individual is described in this paragraph (f)(6)(ii) 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.

(iii) *Individuals within a group of similarly situated individuals.* (A) An individual is described in this paragraph (f)(6)(iii) only if:

(*1*) The individual is a member of a group of similarly situated individuals that is formed for the purpose of traveling or relocating internationally in service of one or more of the purposes listed in section 501(c)(3) or (4), or similarly situated organizations or groups. For example, a group of students that is formed for purposes of traveling and studying abroad for a 6-month period is described in this paragraph (f)(6)(iii);

(*2*) In the case of a group organized to travel or relocate outside the United States, the individual is 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 (or in the case of a policy year that is less than 12 months, at least half the policy year);

(*3*) In the case of a group organized to travel or relocate within the United States, the individual is expected to travel or reside in the United States for not more than 12 months;

(*4*) The individual is not traveling or relocating internationally in connection with an employment-related purpose; and

(*5*) The group meets the test for having associational ties under section 2791(d)(3)(B) through (F) of the PHS Act (42 U.S.C. 300gg–91(d)(3)(B) through (F)).

(B) This paragraph (f)(6)(iii) does not apply to a group that is formed primarily for the sale or purchase of health insurance coverage.

(C) If a group of similarly situated individuals satisfies the requirements of this paragraph (f)(6)(iii), the Secretary of Health and Human Services, in consultation with the Secretary and the Secretary of Labor, has determined that the group requires access to health coverage and other related services and support in multiple countries.

(*7*) *Definition of United States.* Solely for purposes of this paragraph (f), United States means the 50 States, the District of Columbia, and Puerto Rico.

(8) *National of the United States.* For purposes of this paragraph (f), national of the United States, when referring to an individual, has the meaning used in the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*) and includes U.S.

citizens and non-citizen nationals. Thus, for example, an individual born in American Samoa is a national of the United States at birth.

■ 12. Section 54.9833–1 is amended by adding a sentence at the end to read as follows:

§ 54.9833–1 Effective dates.

* * * Notwithstanding the previous sentence, the definition of ''short-term limited duration insurance'' in §§ 54.9801–2 and 5.9831–1(c)(5)(i)(C) and (f) apply for policy years and plan years beginning on or after January 1, 2017.

PART 57—HEALTH INSURANCE PROVIDERS FEE

■ 13. The authority citation for part 57 continues to read in part as follows:

Authority: 26 U.S.C. 7805; sec. 9010, Pub. L. 111–148 (124 Stat. 119 (2010)). * * *

■ 14. Section 57.2 is amended by revising paragraph (n) to read as follows:

§ 57.2 Explanation of terms.

* * * * *

(n) *United States health risk.*—(1) *In general.* The term *United States health risk* means the health risk of any individual who is—

(i) A United States citizen;

(ii) A resident of the United States (within the meaning of section 7701(b)(1)(A)); or

(iii) Located in the United States (within the meaning of paragraph (i) of this section) during the period such individual is so located.

(2) *Qualified expatriates, spouses, and dependents.* The term *United States health risk* does not include the health risk of any individual who is a qualified expatriate (within the meaning of § 54.9831–1(f)(6)) enrolled in an expatriate health plan (within the meaning of § 54.9831–1(f)(3)). For purposes of this paragraph, a qualified expatriate includes any spouse, dependent, or any other individual enrolled in the expatriate health plan.

* * * * *

■ 15. Section 57.4 is amended by adding a sentence to the end of paragraph (b)(2) and adding paragraph (b)(3) to read as follows:

§ 57.4 Fee calculation.

* * * * *

(b) * * *

(2) * * * This presumption does not apply to excluded premiums for qualified expatriates in expatriate health plans as described in § 57.2(n)(2).

(3) *Manner of determining excluded premiums for qualified expatriates in expatriate health plans.* The IRS may specify in other guidance published in the Internal Revenue Bulletin the manner of determining excluded premiums for qualified expatriates in expatriate health plans as described in § 57.2(n)(2).

* * * * *

■ 16. Section 57.10 is amended by revising paragraph (a) and adding paragraph (c) to read as follows:

§ 57.10 Effective/applicability dates.

(a) *In general.* Except as provided in paragraphs (b) and (c) of this section, §§ 57.1 through 57.9 apply to any fee that is due on or after September 30, 2014.

* * * * *

(c) *Qualified expatriates in expatriate health plans.* Section 57.2(n)(2), the last sentence of § 57.4(b)(2), and § 57.4(b)(3) apply to any fee that is due on or after the date the final regulations are published in the **Federal Register**. Until the date the final regulations are published in the **Federal Register**, taxpayers may rely on these rules for any fee that is due on or after September 30, 2018.

PART 301—PROCEDURE AND ADMINSTRATION

■ 17. The authority citation for part 301 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ 18. Section 301.6056–2 is amended by adding paragraph (a)(8) to read as follows:

§ 301.6056–2. Electronic furnishing of statements.

(a) * * *

(8) *Special rule for expatriate health plan coverage*—(i) *In general.* In the case of an individual covered under an expatriate health plan (within the meaning of § 54.9831–1(f)(3) of this chapter), the recipient is treated as having consented under paragraph (a)(2) of this section unless the recipient has explicitly refused to consent to receive the statement in an electronic format. The refusal to consent may be made electronically or in a paper document. A recipient's request for a paper statement is treated as an explicit refusal to receive the statement in electronic format. A furnisher relying on this paragraph (a)(8) must satisfy the requirements of paragraphs (a)(3) through (7) of this section, except that the statement required under paragraph (a)(3) must be provided at least 30 days prior to the time for furnishing under § 301.6056–1(g)(4)(i)(A) of this chapter of the first statement that the furnisher intends to furnish electronically to the recipient, and the other requirements of paragraph (a)(3) are modified to reflect that the statement will be furnished electronically unless the recipient explicitly refuses consent to receive the statement in an electronic format.

(ii) *Manner and time of notifying recipient.* The IRS may specify in other guidance published in the Internal Revenue Bulletin the manner and timing for the initial notification of recipients that the statement required under paragraph (a)(3) of this section will be furnished electronically unless the recipient explicitly refuses to consent to receive the statement in an electronic format. See § 601.601(d)(2)(ii)(B) of this chapter.

(iii) *Effective/applicability date.* The provisions of this paragraph (a)(8) apply as of January 1, 2017.

* * * * *

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor proposes to amend 29 CFR part 2590 as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 19. The authority citation for part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Division M, Pub. L. 113–235, 128 Stat. 2130; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 20. Section 2590.701–2 is amended by:

■ a. Adding in alphabetical order definitions for ''expatriate health insurance issuer'', ''expatriate health plan'', and ''qualified expatriate'';

■ b. Revising the definition of ''short-term, limited-duration insurance''; and

■ c. Adding in alphabetical order a definition for ''travel insurance''.

The additions and revisions read as follows:

§ 2590.701–2 Definitions.

* * * * *

Expatriate health insurance issuer means an expatriate health insurance issuer within the meaning of § 2590.732(f)(2).

Expatriate health plan means an expatriate health plan within the meaning of § 2590.732(f)(3).

* * * * *

Qualified expatriate means a qualified expatriate within the meaning of § 2590.732(f)(6).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract; and

(2) Displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following: ''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.''

* * * * *

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

* * * * *

■ 21. Section 2590.715–2711 is amended by revising paragraph (c) to read as follows:

§ 2590.715–2711 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with—

(1) One of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

* * * * *

■ 22. Section 2590.732 is amended:

■ a. In paragraph (c)(2)(vii) by removing ''and'' at the end;

■ b. In paragraph (c)(2)(viii) by adding ''and'' at the end;

■ c. Adding paragraph (c)(2)(ix);

■ d. Revising paragraph (c)(4)(i);

■ e. Adding paragraph (c)(4)(ii)(D);

■ f. Revising paragraphs (c)(4)(iii) and (c)(5)(i)(C); and

■ g. Adding paragraph (f).

The revisions and additions read as follows:

§ 2590.732 Special rules relating to group health plans.

* * * * *

(c) * * *

(2) * * *

(ix) Travel insurance, within the meaning of § 2590.701–2 of this part.

* * * * *

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if the coverage meets each of the conditions specified in paragraph (c)(4)(ii) of this section.

(ii) * * *

(D) To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other time period, such as per week) of hospitalization or illness (for example, $100/day) without regard to the amount of expenses incurred or the type of items or services received and—

(*1*) The plan or issuer must provide, in any application or enrollment materials provided to participants at or before the time participants are given the opportunity to enroll in the coverage, a notice that prominently displays in at least 14 point type the following language: ''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.''

(*2*) If participants are required to reenroll (in either paper or electronic form) for renewal or reissuance, the notice described in paragraph (c)(4)(ii)(D)(*1*) of this section must be displayed in the reenrollment materials that are provided to the participants at or before the time participants are given the opportunity to reenroll in the coverage.

(*3*) If a notice satisfying the requirements of this paragraph (c)(4)(ii)(D) is timely provided to a participant, the obligation to provide the notice is satisfied for both the plan and the issuer.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example 1,* because the policy pays a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits for doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and prescription drugs at $15 per prescription.

(ii) *Conclusion.* In this *Example 2,* for doctors' visits, surgery, and prescription drugs, payment is not made on a per-period basis, but instead is based on whether a procedure or item is provided, such as whether an individual has surgery or a doctor visit or is prescribed a drug, and the amount of payment varies based on the type of procedure or item. Because benefits related to office visits, surgery, and prescription drugs are not paid based on a fixed dollar amount per day (or per other time period, such as per week), as required under paragraph (c)(4) of this section, the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (c)(4).

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides coverage

through an insurance policy. The policy provides benefits for certain services at a fixed dollar amount per day, but the dollar amount varies by the type of service.

(ii) *Conclusion.* In this *Example 3,* because the policy provides benefits in a different amount per day depending on the type of service, rather than one specific dollar amount per day regardless of the type of service, the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (c)(4).

(5) * * *

(i) * * *

(C) *Similar supplemental coverage provided to coverage under a group health plan.* To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in the primary coverage. The preceding sentence is satisfied if the coverage is designed to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits in the State where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

* * * * *

(f) *Expatriate health plans and expatriate health insurance issuers*—(1) *In general.* With respect to coverage under an expatriate health plan, the requirements of section 715 of ERISA and implementing rules and regulations (incorporating sections 2701 through 2728 of the Public Health Service Act) do not apply to—

(i) An expatriate health plan (as defined in paragraph (f)(3) of this section),

(ii) An employer, solely in its capacity as plan sponsor of an expatriate health plan, and

(iii) An expatriate health insurance issuer (as defined in paragraph (f)(2) of this section) with respect to coverage under an expatriate health plan.

(2) *Definition of expatriate health insurance issuer*—(i) *In general.* Expatriate health insurance issuer means a health insurance issuer, within the meaning of § 2590.701–2, that issues expatriate health plans and that in the course of its normal business operations—

(A) Maintains network provider agreements that provide for direct claims payments, with health care providers in eight or more countries;

(B) Maintains call centers in three or more countries, and accepts calls from customers in eight or more languages;

(C) Processed at least $1 million in claims in foreign currency equivalents during the preceding calendar year, determined using the Treasury Department's currency exchange rate in effect on the last day of the preceding calendar year;

(D) Makes global evacuation/repatriation coverage available;

(E) Maintains legal and compliance resources in three or more countries; and

(F) Has licenses or other authority to sell insurance in more than two countries, including in the United States.

(ii) *Additional rules.* For purposes of meeting the requirements of this paragraph (f)(2), two or more entities, including one entity that is the expatriate health insurance issuer, that are members of the expatriate health insurance issuer's controlled group (as determined under 26 CFR 57.2(c)) are treated as one expatriate health insurance issuer. Alternatively, the requirements of this paragraph (f)(2) may be satisfied through contracts between an expatriate health insurance issuer and third parties.

(3) *Definition of expatriate health plan.* Expatriate health plan means a plan that satisfies the requirements of paragraphs (f)(3)(i) through (iii) of this section.

(i) *Substantially all qualified expatriates requirement.* Substantially all primary enrollees in the expatriate health plan must be qualified expatriates. For purposes of this paragraph (f)(3)(i), the primary enrollee is the individual covered by the plan or policy whose eligibility for coverage is not due to that individual's status as the spouse, dependent, or other beneficiary of another covered individual. Notwithstanding the foregoing, an individual is not a primary enrollee if the individual is not a national of the United States and the individual resides in his or her country of citizenship. A plan satisfies the requirement of this paragraph (f)(3)(i) for a plan or policy year only if, on the first day of the plan or policy year, less than 5 percent of the primary enrollees (or less than 5 primary enrollees if greater) are not qualified expatriates.

(ii) *Substantially all benefits not excepted benefits requirement.* Substantially all of the benefits provided under the plan or coverage must be benefits that are not excepted benefits described in § 2590.732(c).

(iii) *Additional requirements.* To qualify as an expatriate health plan, the plan or coverage must also meet the following requirements:

(A) The plan or coverage provides coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services (comparable to emergency services coverage that was described in and offered under section 8903(1) of title 5, United States Code for plan year 2009) in the following locations—

(*1*) In the case of individuals described in paragraph (f)(6)(i) of this section, in the United States and in the country or countries from which the individual was transferred or assigned, and such other country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate;

(*2*) In the case of individuals described in paragraph (f)(6)(ii) of this section, in the country or countries in which the individual is present in connection with his employment, and such other country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate; or

(*3*) In the case of individuals described in paragraph (f)(6)(iii) of this section, in the country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate.

(B) The plan sponsor reasonably believes that benefits provided by the plan or coverage satisfy the minimum value requirements of Internal Revenue Code section 36B(c)(2)(C)(ii). For this purpose, a plan sponsor is permitted to rely on the reasonable representations of the issuer or administrator regarding whether benefits offered by the issuer or group health plan satisfy the minimum value requirements unless the plan sponsor knows or has reason to know that the benefits fail to satisfy the minimum value requirements.

(C) In the case of a plan or coverage that provides dependent coverage of children, such coverage must be available until an individual attains age 26, unless an individual is the child of a child receiving dependent coverage.

(D) The plan or coverage is:

(*1*) In the case of individuals described in paragraph (f)(6)(i) or (ii) of this section, a group health plan (including health insurance coverage offered in connection with a group health plan), issued by an expatriate health insurance issuer or administered by an expatriate health plan administrator. A group health plan will not fail to be an expatriate health plan

merely because any portion of the coverage is provided through a self-insured arrangement.

(*2*) In the case of individuals described in paragraph (f)(6)(iii) of this section, health insurance coverage issued by an expatriate health insurance issuer.

(E) The plan or coverage offers reimbursements for items or services in local currency in eight or more countries.

(F) The plan or coverage satisfies the provisions of this part as in effect on March 22, 2010. For this purpose, the plan or coverage is not required to comply with section 701(e) (relating to certification of creditable coverage) and underlying regulations. However, to the extent the plan or coverage imposes a preexisting condition exclusion, the plan or coverage must ensure that individuals with prior creditable coverage who enroll in the plan or coverage have an opportunity to demonstrate that they have creditable coverage offsetting the preexisting condition exclusion.

(iv) *Example.* The rule of paragraph (f)(3)(i) of this section is illustrated by the following example:

Example. (i) *Facts.* Business has health plan X for 250 U.S. citizens working outside of the United States in Country Y. All of the U.S. citizens working in Country Y satisfy the requirements to be qualified expatriates under § 2590.732(f)(6)(ii). In addition to the 250 U.S. citizens, Business employs 100 citizens of Country Y who reside in Country Y and do not satisfy the requirements to be qualified expatriates under § 2590.732(f)(6)(ii). Health plan X covers both the U.S. citizens and citizens of Country Y.

(ii) *Conclusion.* Health plan X satisfies the requirement of § 2590.732(f)(3)(i) that substantially all primary enrollees of an expatriate health plan be qualified expatriates because 100 percent of the primary enrollees are qualified expatriates. The 100 citizens of Country Y who reside in Country Y are not treated as primary enrollees for purposes of the substantially all requirement of § 2590.732(f)(3)(i) because they are not nationals of the United States and they reside in the country of their citizenship.

(4) *Definition of expatriate health plan administrator*—(i) *In general.* Expatriate health plan administrator means an administrator that in the course of its regular business operations—

(A) Maintains network provider agreements that provide for direct claims payments, with health care providers in eight or more countries,

(B) Maintains call centers, in three or more countries, and accepts calls from customers in eight or more languages,

(C) Processed at least $1 million in claims in foreign currency equivalents during the preceding calendar year, determined using the Treasury Department's currency exchange rate in effect on the last day of the preceding calendar year,

(D) Makes global evacuation/repatriation coverage available,

(E) Maintains legal and compliance resources in three or more countries, and

(F) Has licenses or other authority to sell insurance in more than two countries, including in the United States.

(ii) *Additional rules.* For purposes of meeting the requirements of this paragraph (f)(4), two or more entities, including one entity that is the expatriate health plan administrator, that are members of the expatriate health plan administrator's controlled group (as determined under 26 CFR 57.2(c)) are treated as one expatriate health plan administrator. Alternatively, the requirements of this paragraph (f)(4) may be satisfied through contracts between an expatriate health plan administrator and third parties.

(5) *Definition of group health plan.* Group health plan, for purposes of this section, means a group health plan as defined in § 2590.732(a).

(6) *Definition of qualified expatriate.* Qualified expatriate, for purposes of this section, means an individual who is described in paragraph (f)(6)(i), (ii) or (iii) of this section.

(i) *Individuals transferred or assigned by their employer to work in the United States.* An individual is described in this paragraph (f)(6)(i) only if such individual has the skills, qualifications, job duties, or expertise that has caused the individual's employer to transfer or assign the individual to the United States for a specific and temporary purpose or assignment that is tied to the individual's employment with such employer. This paragraph (f)(6)(i) applies only to an individual who the plan sponsor has reasonably determined requires access to health coverage and other related services and support in multiple countries, and is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross-border moving expenses, or compensation to enable the individual to return to the individual's home country), and does not apply to any individual who is a national of the United States. For purposes of this paragraph (f)(6)(i), 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 and other related services and support in multiple countries. Furthermore, the offer of a one-time *de minimis* benefit would not meet the standard for the offer of other multinational benefits on a periodic basis.

(ii) *Individuals working outside the United States.* An individual is described in this paragraph (f)(6)(ii) 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.

(iii) *Individuals within a group of similarly situated individuals.* (A) An individual is described in this paragraph (f)(6)(iii) only if:

(*1*) The individual is a member of a group of similarly situated individuals that is formed for the purpose of traveling or relocating internationally in service of one or more of the purposes listed in Internal Revenue Code section 501(c)(3) or (4), or similarly situated organizations or groups. For example, a group of students that is formed for purposes of traveling and studying abroad for a 6-month period is described in this paragraph (f)(6)(iii);

(*2*) In the case of a group organized to travel or relocate outside the United States, the individual is 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 (or in the case of a policy year that is less than 12 months, at least half the policy year);

(*3*) In the case of a group organized to travel or relocate within the United States, the individual is expected to travel or reside in the United States for not more than 12 months;

(*4*) The individual is not traveling or relocating internationally in connection with an employment-related purpose; and

(*5*) The group meets the test for having associational ties under section 2791(d)(3)(B) through (F) of the PHS Act (42 U.S.C. 300gg–91(d)(3)(B) through (F)).

(B) This paragraph (f)(6)(iii) does not apply to a group that is formed primarily for the sale or purchase of health insurance coverage.

(C) If a group of similarly situated individuals satisfies the requirements of this paragraph (f)(6)(iii), the Secretary of Health and Human Services, in consultation with the Secretary and the Secretary of the Treasury, has determined that the group requires access to health coverage and other related services and support in multiple countries.

(7) *Definition of United States.* Solely for purposes of this paragraph (f),

United States means the 50 States, the District of Columbia, and Puerto Rico.

(8) *National of the United States.* For purposes of this paragraph (f), national of the United States, when referring to an individual, has the meaning used in the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*) and includes U.S. citizens and non-citizen nationals. Thus, for example, an individual born in American Samoa is a national of the United States at birth.

■ 23. Section 2590.736 is amended by adding a sentence at the end to read as follows:

§ 2590.736 Applicability dates.

* * * Notwithstanding the previous sentences, the definition of ''short-term, limited-duration insurance'' in §§ 2590.701–2 and 2590.732(c)(5)(i)(C) and (f) apply for plan years beginning on or after January 1, 2017.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Chapter 1

For the reasons stated in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 144, 146, 147, 148, and 158 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 24. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 25. Section 144.103 is amended by:
■ a. Adding in alphabetical order definitions for ''expatriate health insurance issuer'', ''expatriate health plan'', and ''qualified expatriate'';
■ b. Revising the definition of ''short-term, limited-duration insurance''; and
■ c. Adding in alphabetical order a definition for ''travel insurance''.

The additions and revision read as follows:

§ 144.103 Definitions.

* * * * *

Expatriate health insurance issuer means an expatriate health insurance issuer within the meaning of § 147.170(b) of this subchapter.

Expatriate health plan means an expatriate health plan within the meaning of § 147.170(c) of this subchapter.

* * * * *

Qualified expatriate means a qualified expatriate within the meaning of § 147.170(f) of this subchapter.

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract; and

(2) Displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following: ''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.''

* * * * *

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

* * * * *

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 26. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92.

■ 27. Section 146.145 is amended by:
■ a. Adding paragraph (b)(2)(ix);
■ b. Revising paragraph (b)(4)(i);
■ c. Adding paragraph (b)(4)(ii)(D); and
■ d. Revising paragraph (b)(5)(i)(C).

The additions and revisions read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) * * *

(2) * * *

(ix) Travel insurance, within the meaning of § 144.103 of this subchapter.

* * * * *

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if the coverage meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) * * *

(D) To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other time period, such as per week) of hospitalization or illness (for example, $100/day) without regard to the amount of expenses incurred or the type of items or services received and—

(*1*) The plan or issuer must provide, in any application or enrollment materials provided to participants at or before the time participants are given the opportunity to enroll in the coverage, a notice that prominently displays in at least 14 point type the following language: ''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.''

(*2*) If participants are required to reenroll (in either paper or electronic form) for renewal or reissuance, the notice described in paragraph (b)(4)(ii)(D)(*1*) of this section must be displayed in the reenrollment materials that are provided to the participants at or before the time participants are given the opportunity to reenroll in the coverage.

(*3*) If a notice satisfying the requirements of this paragraph (b)(4)(ii)(D) is timely provided to a participant, the obligation to provide the notice is satisfied for both the plan and the issuer.

(iii) *Examples.* The rules of this paragraph (b)(4) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy

provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example 1,* because the policy pays a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (b)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits for doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and prescription drugs at $15 per prescription.

(ii) *Conclusion.* In this *Example 2,* for doctors' visits, surgery, and prescription drugs, payment is not made on a per-period basis, but instead is based on whether a procedure or item is provided, such as whether an individual has surgery or a doctor visit or is prescribed a drug, and the amount of payment varies based on the type of procedure or item. Because benefits related to office visits, surgery, and prescription drugs are not paid based on a fixed dollar amount per day (or per other time period, such as per week), as required under paragraph (b)(4) of this section, the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (b)(4).

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits for certain services at a fixed dollar amount per day, but the dollar amount varies by the type of service.

(ii) *Conclusion.* In this *Example 3,* because the policy provides benefits in a different amount per day depending on the type of service, rather than one specific dollar amount per day regardless of the type of service, the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under this paragraph (b)(4).

(5) * * *

(i) * * *

(C) *Similar supplemental coverage provided to coverage under a group health plan.* To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in the primary coverage. The preceding sentence is satisfied if the coverage is designed to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits in the State where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

* * * * *

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 28. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 29. Section 147.126 is amended by revising paragraph (c) to read as follows:

§ 147.126 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with—

(1) One of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

* * * * *

■ 30. Section 147.170 is added to read as follows:

§ 147.170 Expatriate health plans and expatriate health insurance issuers.

(a) *In general.* With respect to coverage under an expatriate health plan, the requirements of (including any amendment made by) the Patient Protection and Affordable Care Act and of title I and subtitle B of title II of the Health Care and Education and Reconciliation Act of 2010, and implementing rules and regulations do not apply to—

(1) An expatriate health plan (as defined in paragraph (c) of this section),

(2) An employer, solely in its capacity as plan sponsor of an expatriate health plan, and

(3) An expatriate health insurance issuer (as defined in paragraph (b) of this section) with respect to coverage under an expatriate health plan.

(b) *Definition of expatriate health insurance issuer*—(1) *In general.* Expatriate health insurance issuer means a health insurance issuer, within the meaning of § 144.103 of this subchapter, that issues expatriate health plans and that in the course of its normal business operations—

(i) Maintains network provider agreements that provide for direct claims payments, with health care providers in eight or more countries;

(ii) Maintains call centers in three or more countries, and accepts calls from customers in eight or more languages;

(iii) Processed at least $1 million in claims in foreign currency equivalents during the preceding calendar year, determined using the Treasury Department's currency exchange rate in effect on the last day of the preceding calendar year;

(iv) Makes global evacuation/repatriation coverage available;

(v) Maintains legal and compliance resources in three or more countries; and

(vi) Has licenses or other authority to sell insurance in more than two countries, including in the United States.

(2) *Additional rules.* For purposes of meeting the requirements of this paragraph (b), two or more entities, including one entity that is the expatriate health insurance issuer, that are members of the expatriate health insurance issuer's controlled group (as determined under 26 CFR 57.2(c)) are treated as one expatriate health insurance issuer. Alternatively, the requirements of this paragraph (b) may be satisfied through contracts between an expatriate health insurance issuer and third parties.

(c) *Definition of expatriate health plan.* Expatriate health plan means a plan that satisfies the requirements of paragraphs (c)(1) through (3) of this section.

(1) *Substantially all qualified expatriates requirement.* Substantially all primary enrollees in the expatriate health plan must be qualified expatriates. For purposes of this paragraph (c)(1), the primary enrollee is the individual covered by the plan or policy whose eligibility for coverage is not due to that individual's status as the spouse, dependent, or other beneficiary of another covered individual. Notwithstanding the foregoing, an individual is not a primary enrollee if the individual is not a national of the United States and the individual resides in his or her country of citizenship. A plan satisfies the requirement of this

paragraph (c)(1) for a plan or policy year only if, on the first day of the plan or policy year, less than 5 percent of the primary enrollees (or less than 5 primary enrollees if greater) are not qualified expatriates.

(2) *Substantially all benefits not excepted benefits requirement.* Substantially all of the benefits provided under the plan or coverage must be benefits that are not excepted benefits described in § 146.145(b) and § 148.220 of this subchapter.

(3) *Additional requirements.* To qualify as an expatriate health plan, the plan or coverage must also meet the following requirements:

(i) The plan or coverage provides coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services (comparable to emergency services coverage that was described in and offered under section 8903(1) of title 5, United States Code for plan year 2009) in the following locations—

(A) In the case of individuals described in paragraph (f)(1) of this section, in the United States and in the country or countries from which the individual was transferred or assigned, and such other country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate;

(B) In the case of individuals described in paragraph (f)(2) of this section, in the country or countries in which the individual is present in connection with his employment, and such other country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate; or

(C) In the case of individuals described in paragraph (f)(3) of this section, in the country or countries the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and Secretary of Labor, may designate.

(ii) The plan sponsor reasonably believes that benefits provided by the plan or coverage satisfy the minimum value requirements of section 36B(c)(2)(C)(ii) of the Internal Revenue Code. For this purpose, a plan sponsor is permitted to rely on the reasonable representations of the issuer or administrator regarding whether benefits offered by the issuer or group health plan satisfy the minimum value requirements unless the plan sponsor knows or has reason to know that the benefits fail to satisfy the minimum value requirements.

(iii) In the case of a plan or coverage that provides dependent coverage of children, such coverage must be available until an individual attains age 26, unless an individual is the child of a child receiving dependent coverage.

(iv) The plan or coverage is:

(A) In the case of individuals described in paragraphs (f)(1) or (f)(2) of this section, a group health plan (including health insurance coverage offered in connection with a group health plan), issued by an expatriate health insurance issuer or administered by an expatriate health plan administrator. A group health plan will not fail to be an expatriate health plan merely because any portion of the coverage is provided through a self-insured arrangement.

(B) In the case of individuals described in paragraph (f)(3) of this section, health insurance coverage issued by an expatriate health insurance issuer.

(v) The plan or coverage offers reimbursements for items or services in local currency in eight or more countries.

(vi) The plan or coverage satisfies the provisions of title XXVII of the Public Health Service Act (42 U.S.C. 300gg *et seq.*) and regulations thereunder as in effect on March 22, 2010. For this purpose, the plan or coverage is not required to comply with section 2701(e) (relating to certification of creditable coverage) and underlying regulations. However, to the extent the plan or coverage imposes a preexisting condition exclusion, the plan or coverage must ensure that individuals with prior creditable coverage who enroll in the plan or coverage have an opportunity to demonstrate that they have creditable coverage offsetting the preexisting condition exclusion.

(v) Example. The rule of paragraph (c)(1) of this section is illustrated by the following example:

Example. (i) *Facts.* Business has health plan X for 250 U.S. citizens working outside of the United States in Country Y. All of the U.S. citizens working in Country Y satisfy the requirements to be qualified expatriates under § 147.170(f)(2). In addition to the 250 U.S. citizens, Business employs 100 citizens of Country Y who reside in Country Y and do not satisfy the requirements to be qualified expatriates under § 147.170(f). Health plan X covers both the U.S. citizens and citizens of Country Y.

(ii) *Conclusion.* Health plan X satisfies the requirement of § 147.170(c)(1) that substantially all primary enrollees of an expatriate health plan be qualified expatriates because 100 percent of the primary enrollees are qualified expatriates. The 100 citizens of Country Y who reside in Country Y are not treated as primary enrollees for purposes of the substantially all requirement of § 147.170(c)(1) because they are not nationals of the United States and they reside in the country of their citizenship.

(d) *Definition of expatriate health plan administrator*—(1) *In general.* Expatriate health plan administrator means an administrator that in the course of its regular business operations—

(i) Maintains network provider agreements that provide for direct claims payments, with health care providers in eight or more countries,

(ii) Maintains call centers, in three or more countries, and accepts calls from customers in eight or more languages,

(iii) Processed at least $1 million in claims in foreign currency equivalents during the preceding calendar year, determined using the Treasury Department's currency exchange rate in effect on the last day of the preceding calendar year,

(iv) Makes global evacuation/repatriation coverage available,

(v) Maintains legal and compliance resources in three or more countries, and

(vi) Has licenses or other authority to sell insurance in more than two countries, including in the United States.

(2) *Additional rules.* For purposes of meeting the requirements of this paragraph (d), two or more entities, including one entity that is the expatriate health plan administrator, that are members of the expatriate health plan administrator's controlled group (as determined under 26 CFR 57.2(c)) are treated as one expatriate health plan administrator. Alternatively, the requirements of this paragraph (d) may be satisfied through contracts between an expatriate health plan administrator and third parties.

(e) *Definition of group health plan.* Group health plan, for purposes of this section, means a group health plan as defined in § 146.145(a) of this subchapter.

(f) *Definition of qualified expatriate.* Qualified expatriate, for purposes of this section, means an individual who is described in paragraph (f)(1), (2), or (3) of this section.

(1) *Individuals transferred or assigned by their employer to work in the United States.* An individual is described in this paragraph (f)(1) only if such individual has the skills, qualifications, job duties, or expertise that has caused the individual's employer to transfer or assign the individual to the United States for a specific and temporary purpose or assignment that is tied to the individual's employment with such

employer. This paragraph (f)(1) applies only to an individual who the plan sponsor has reasonably determined requires access to health coverage and other related services and support in multiple countries, and is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross-border moving expenses, or compensation to enable the individual to return to the individual's home country), and does not apply to any individual who is a national of the United States. For purposes of this paragraph (f)(1), 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 and other related services and support in multiple countries. Furthermore, the offer of a one-time *de minimis* benefit would not meet the standard for the offer of other multinational benefits on a periodic basis.

(2) *Individuals working outside the United States.* An individual is described in this paragraph (f)(2) 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.

(3) *Individuals within a group of similarly situated individuals.* (i) An individual is described in this paragraph (f)(3) only if:

(A) The individual is a member of a group of similarly situated individuals that is formed for the purpose of traveling or relocating internationally in service of one or more of the purposes listed in section 501(c)(3) or (4) of the Internal Revenue Code, or similarly situated organizations or groups. For example, a group of students that is formed for purposes of traveling and studying abroad for a 6-month period is described in this paragraph (f)(3);

(B) In the case of a group organized to travel or relocate outside the United States, the individual is 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 (or in the case of a policy year that is less than 12 months, at least half the policy year);

(C) In the case of a group organized to travel or relocate within the United States, the individual is expected to travel or reside in the United States for not more than 12 months;

(D) The individual is not traveling or relocating internationally in connection with an employment-related purpose; and

(E) The group meets the test for having associational ties under section 2791(d)(3)(B) through (F) of the Public Health Service Act (42 U.S.C. 300gg–91(d)(3)(B) through (F)).

(ii) This paragraph (f)(3) does not apply to a group that is formed primarily for the sale or purchase of health insurance coverage.

(iii) If a group of similarly situated individuals satisfies the requirements of this paragraph (f)(3), the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, has determined that the group requires access to health coverage and other related services and support in multiple countries.

(g) *Definition of United States.* Solely for purposes of this section, United States means the 50 States, the District of Columbia, and Puerto Rico.

(h) *National of the United States.* For purposes of this section, national of the United States, when referring to an individual, has the meaning used in the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*) and includes U.S. citizens and non-citizen nationals. Thus, for example, an individual born in American Samoa is a national of the United States at birth.

(i) *Applicability date.* The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2017.

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

■ 31. The authority citation for part 148 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 32. Section 148.220 is amended by adding paragraph (a)(9) to read as follows:

§ 148.220 Excepted benefits.

* * * * *

(a) * * *

(9) Travel insurance, within the meaning of § 144.103 of this subchapter.

* * * * *

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

■ 33. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18), as amended.

■ 34. Section 158.120 is amended by revising paragraph (d)(4) to read as follows:

§ 158.120 Aggregate Reporting.

* * * * *

(d) * * *

(4) An issuer with group policies that provide coverage to employees, substantially all of whom are: Working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country, must aggregate and report the experience from these policies on a national basis, separately for the large group market and small group market, and separately from other policies, except that coverage offered by an issuer with respect to an expatriate health plan (within the meaning of § 147.170(c) of this subchapter) is not subject to the reporting and rebate requirements of 45 CFR part 158.

* * * * *

[FR Doc. 2016–13583 Filed 6–8–16; 11:15 am]

BILLING CODE 4830–01–P; 4510–29–P; 4120–01–P